



**COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES**



PROVIDER AGENCY ADVISORY COMMITTEE

MEETING NOTICE

The Provider Agency Advisory Committee meetings are open to the public. You may address this Committee on any agenda item before or during consideration of that item, and on other items of interest that are not on the agenda, but which are within the subject matter jurisdiction of this Committee.

DATE: December 18, 2024

TIME: 1:00 pm

LOCATION: IN-PERSON MEETING
Cathy Chidester Conference Room [1st Floor Hearing Room]
Los Angeles County EMS Agency
10100 Pioneer Boulevard
Santa Fe Springs, California 90670

AGENDA

1. CALL TO ORDER

2. INTRODUCTIONS / ANNOUNCEMENTS / PRESENTATIONS

- 2.1 Provider Agency Hospital Emergency Response Team (HERT) Drills
- 2.2 EMSAAC 2025 Annual Conference

3. APPROVAL OF MINUTES: October 16, 2024

4. UNFINISHED BUSINESS

Policies for Discussion; Action Required:

- 4.1 Reference No. 519, Management of Multiple Casualty Incidents

Policies for Discussion; No Action Required:

- 4.2 Reference No. 1200.2, Treatment Protocol: Base Contact Requirements
- 4.3 Reference No. 1209 / 1209-P, Treatment Protocol: Behavioral / Psychiatric Crisis

5. NEW BUSINESS

- 5.1 Pediatric Surge Plan
- 5.2 Cognito Form

Policies for Discussion; No Action Required:

- 5.3 Reference No. 505, Ambulance Patient Offload Time (APOT)
- 5.4 Reference No. 1317.XX Hydroxocobalamin
 - 5.4.1 Reference No. 803 / 803.1, Los Angeles County Paramedic Scope of Practice
 - 5.4.2 Reference No. 1236 / 1236-P, Treatment Protocol: Inhalation Injury
 - 5.4.3 Reference No. 1238 / 1238-P, Treatment Protocol: Carbon Monoxide Exposure

5.4.4 Reference No. 1240 / 1240-P, Treatment Protocol: HAZMAT

5.4.5 Reference No. 1300, Medical Control Guidelines (Table of Contents)

5.5 Reference No. 13XX, Medical Control Guideline: Evaluation and Care of Patients at Risk of Suicide

6. REPORTS AND UPDATES

6.1 EMS Update 2025

6.2 EmergiPress

6.3 ITAC Update (*Tabled*)

6.4 Research Initiatives and Pilot Studies

6.4.1 Prehospital Blood Transfusion

6.4.2 ECMO

6.4.3 ThoraSite Pilot

6.5 PediDOSE Trial

6.6 Pedi-PART

6.7 California Office of Traffic Safety (OTS) Grants Projects

6.7.1 Mobile Protocol Application

6.7.2 Trauma Dashboard

6.8 ELCOR Task Force

6.9 ALS Skill Sheets

7. OPEN DISCUSSION

8. NEXT MEETING: February 12, 2025

9. ADJOURNMENT



2025 Annual
Conference

**SAVE
THE
DATE**

MAY 28 & 29, 2025

Loews Coronado Hotel, San Diego

California Dreamin'

United in Our Mission

Pre-Conference, May 27: California Screamin' - Your Disaster Medical Response

Presented by: EMS Administrators' Association of California
Monitor the EMSAAC website for current information: www.EMSAAC.org



EMERGENCY MEDICAL SERVICES COMMISSION PROVIDER AGENCY ADVISORY COMMITTEE



MINUTES

Wednesday, October 16, 2024

MEMBERSHIP / ATTENDANCE

MEMBERS IN ATTENDANCE	ORGANIZATION	EMS AGENCY STAFF	EMS AGENCY STAFF
X Kenneth Powell, Chair	EMSC, Commissioner	Nichole Bosson, MD	Denise Whitfield, MD
Paul Espinosa, Vice-Chair	EMSC, Commissioner	Shira Schlesinger, MD	Jake Toy, MD
James Lott, PsyD, MBA	EMSC, Commissioner	Chris Clare	Michael Kim, MD
Ken Lieberman	EMSC, Commissioner	Roel Amara	Jacqueline Rifenburg
Jason Cervantes	EMSC, Commissioner	Bijan Arab, MD	Jonathon Warren, MD
Carol Kim	EMSC, Commissioner	Ami Boonjaluksa	Jennifer Calderon
Carol Meyer	EMSC, Commissioner	Paula Cho	Lily Choi
Gary Washburn	EMSC, Commissioner	Terry Crammer	Mark Ferguson
		Natalie Greco	Tracy Harada
X Sean Stokes	Area A (<i>Rep to Medical Council</i>)	HanNa Kang	Laura Leyman
X Patrick Nulty	Area A, Alternate	Lorna Mendoza	Sandra Montero
X Keith Harter	Area B	Mariana Munatones	Nnabuike Nwanonyeni
X Clayton Kazan, MD	Area B, Alternate	Lorrie Perez	Sara Rasnake
X Todd Tucker	Area C	Gary Watson	Gerard Waworundeng
Jeffrey Tsay	Area C, Alternate	David Wells	Christine Zaiser
X Ryan Jorgensen	Area E		
X Geoffrey Dayne	Area E, Alternate	GUEST	ORGANIZATION
X Joel Davis	Area F	Dawn Terashita, MD	LA County Public Health
Andrew Reno	Area F, Alternate	Erick Cheung, MD	UCLA Health
X Adam Brown	Area G (<i>Rep to BHAC</i>)	Ilse Wogan	LACoFD
X Stefan Viera	Area G, Alternate	Ryan Ockey	LAFD
X Matthew Conroy	Area H	Ben Esparza	LAFD
Tim Wuerfel	Area H, Alternate	Heidi Ruff	LAFD – Air Operations
David Hahn	Area H, Alternate	Jim Goldsworthy	LAFD – Air Operations
Julian Hernandez	Employed Paramedic Coordinator	Nanci Medina	LAFD
Tisha Hamilton	Employed Paramedic Coordinator, Alt	Valentina Triamarit	LACoFD
Rachel Caffey	Prehospital Care Coordinator	Catherine Borman	Santa Monica FD
X Jenny Van Slyke	Prehospital Care Coordinator, Alternate	Kristina Crews	LACoFD
X Bryan Sua	Public Sector Paramedic Coordinator	Issac Yang	Redondo Beach FD
<i>Vacant</i>	Public Sector Paramedic Coordinator, Alt	Michelle Evans	West Coast Ambulance
Maurice Guillen	Private Sector Paramedic	Ryan Shook	Santa Monica FD
Scott Buck	Private Sector Paramedic, Alternate	Travis Moore	La Verne FD
X Tabitha Cheng, MD	Provider Agency Medical Director	Patricia Guevara	Burbank FD
X Tiffany Abramson, MD	Provider Agency Medical Director, Alt	Alfredo Estrada	Montebello FD
X Robert Ower	Private Sector Nurse Staffed Amb Program	Freddy Jimenez	Montebello FD
Jonathan Lopez	Private Sector Nurse Staffed Amb Program,	Ivy Valenzuela	LA County Public Health
Scott Jaeggi	EMT Training Program	Peter Garcia	Burbank FD
X Albert Laicans	EMT Training Program, Alternate	Adrienne Roel	UCLA Ctr for Prehosp Care
Ray Mosack	Paramedic Training Program	Michael Stone, MD	LA General – EMS Fellow
<i>Vacant</i>	Paramedic Training Program, Alternate	Marc Cohen, MD	Medical Director, Multiple FDs
X Caroline Jack	EMS Educator	Rom Rubimian, MD	LAFD
X Jennifer Nulty	EMS Educator, Alternate	Joe Nakagawa, MD	Medical Director, Hawthorne PD
		Salvador Rios, MD	Medical Director, Monrovia FD
		Toni Arellano	LACoFD
		Kristina Hong	Downey FD
		Sergio Zavala	Downey FD
		Kelsey Wilhelm, MD	Medical Director, Compton FD
		Puneet Gupta, MD	Assist Med Director, LACoFD
		Armando Jurado	Lifeline Ambulance
		Jessi Castillo	PRN Ambulance

1. CALL TO ORDER – Chair Kenneth Powell, called meeting to order at 1:01 p.m.

2. INTRODUCTIONS AND ANNOUNCEMENTS

2.1 Los Angeles County’s Health Officer Order No. 2024.01.01 (*Dawn Terashita, MD; LA County Public Health*)

- The current Health Officer Order was reviewed including the requirements for receiving and tracking the influenza and COVID-19 vaccines within each provider agency.
- Dr. Terashita presented a review of the Marburg Virus that is currently in the Republic of Rwanda. Currently, there are no reported cases in the United States.

- Providers are encouraged to continue following blood and body fluid precautions, utilizing personal protective equipment.
- Terry Cramer, EMS Agency Disaster Services, announced that the EMS Agency is updating three policies to include information on the Marburg Virus; these policies will be sent to all providers once completed.
- Los Angeles County has three specialty pathogen treatment centers: Kaiser Foundation Hospital - Los Angeles (KFL), Ronald Reagan UCLA Medical Center (UCL) and Cedars Sinai Medical Center (CSM).

2.2 PAAC Membership Changes (*Chair, Kenneth Powell*)

- Area A, Alternate: Patrick Nulty, BC, Santa Monica FD
- Area E, Representative: Ryan Jorgensen, La Habra Heights FD
- Area E, Alternate: Geoffrey Dayne, Santa Fe Spring Fire Rescue.
- Area F, Representative: Joel Davis, Long Beach FD
- Area H, Alternate: Tim Wuerfel, BC, Los Angeles Fire Department.
- Nurse Staffed Ambulance, Representative: Robert Ower, Premier Ambulance.
- Paramedic Training Programs, Representative: Raymond Mosack, Mount San Antonio College

3. APPROVAL OF MINUTES (*Harter/Tucker*) August 21, 2024, minutes were approved as written.

4. REPORTS & UPDATES

4.1 EMS Update 2025 (*Shira Schlesinger, MD*)

- Preparation for EMS Update 2025 as begun. The first planning committee meeting will occur in November 2024; invitations will be sent soon.
- If interested in being part of this planning committee and have not heard from Dr. Schlesinger yet, please email her at sschlesinger2@dhs.lacounty.gov
- The current plan is to complete Train-the-Trainer classes by the end of March 2025, start provider agency training in April 2025 and end in June 2025.

4.2 Emergi-Press (*Shira Schlesinger, MD*)

- The September 2024 Emergi-Press is now available on the EMS Agency's webpage, APS platform and Target Solutions.
- After inquiry, it was identified that the public providers are utilizing an APS platform to complete the online training and private providers are printing hard copies of the educational material directly from the EMS Agency's webpage to complete the education. Note: EMS Update and EmergiPress is available to all private provider accredited paramedics via the EMS Agency APS site.

4.3 ITAC Update

- Tabled until next meeting.

4.4 Research Initiatives and Pilot Studies (*Nichole Bosson, MD*)

4.4.1 ECMO Pilot

- Data collection for the pilot has completed. Data collection is now being completed through the EMS Agency SRC database.
- There have been >200 patients enrolled in this pilot, with approximately 50 patients treated with eCPR and nearly a 30% survival rate (previously, survival rate of refractory V-fib [<5%]).
- Once the data analysis is complete, results will be shared to this Committee.
- At this time, the existing ECMO Centers will continue to receive patients meeting the ECMO criteria and only the existing ECMO pilot providers will continue operating under the pilot protocol.
- During EMS Update 2025, it is planned to have all provider agencies trained on ECMO protocol.

4.4.2 Prehospital Blood Transfusion (Nichole Bosson, MD)

- Los Angeles County has received authorization from the California EMS Authority to implement the prehospital administration of blood transfusions (either whole blood or packed red blood cells).
- Providers participating in this Pilot include Los Angeles County FD and Compton FD.
- LA County EMS will be working with four other California EMS Agencies in collecting data over the next two years of this pilot; with an anticipated start date in the spring of 2025.

4.4.3 ThoraSite (Denise Whitfield, MD)

- The EMS Agency is continuing to monitor the use of this landmarking device for needle thoracostomies from four participating provider agencies.
- Currently, there has been 175 needle thoracostomy placements.
- The plan is to complete this Pilot at the end of this calendar year (2024), at which time the EMS Agency will review the aggregate data. Once data has been analyzed, information will be presented back to this Committee.

4.5 PediDOSE Trial (Nichole Bosson, MD)

- Dr. Bosson reviewed a chart summarizing the compliance rates for the paramedic self-reports (PSR). The goal is to have paramedics complete a PSR on all pediatric seizure responses.
- Provider agencies were reminded to ensure that all parents/caregivers are notified of their child's enrollment into the study. Also, to collect parent/caregiver's name and phone numbers. This is a federal requirement for this study.
- Committee member requested a list of patient care records that indicate no PSR completion. This would allow provider agencies to educate their personnel to improve compliance rates. The EMS Agency will collaborate with CHLA to provide the provider agencies with the requested information.

4.6 Pedi-PART (Nichole Bosson, MD)

- Completion of PSRs continue to do well with nearly 100% compliance.
- The RALPH devices have been distributed to all public providers. The RALPH device provides the field paramedic with information on which airway device to be utilized for the specific day (i-gel vs bag-mask-ventilation [BMV]). For those who have not received this device, contact Terry Crammer at tcrammer@dhs.lacounty.gov
- The current challenge with the study is with randomization. (i-gels are being placed on BMV days; and only BMVs are being used on the i-gel days.) Paramedics were reminded to continue following the correct randomization schedule, which is provided by utilizing the RALPH device.
- Providers were also reminded to ensure placement of the defibrillation pads on all patients in this study. Replacement defibrillation pads can be supplied by the EMS Agency upon request.
- Providers who do not have the Zoll cardiac monitor case review program, can now access this through your Zoll representative at no charge.

4.7 California Office of Traffic Safety (OTS) Grants Projects

4.7.1 Mobile Protocol Application (Nichole Bosson, MD and Denise Whitfield, MD)

- Train-the-Trainer for this protocol application was completed earlier this month and recordings of this training will be available on the EMS Agency webpage for future use.
- The application is now available for Beta testing by the providers.
- At the end of October 2024 and after additional modifications, the final version of this application will be released for systemwide use.
- Once released, the application will be routinely updated by the EMS Agency, allowing for access to up-to-date information by providers.

4.7.2 Trauma Dashboards/Curriculum (Shira Schlesinger, MD)

- Patient assessment elements have been filmed for the first module of the training for the trauma dashboard. This module is planned to be released within the next couple of months. Thank you to Torrance Fire Department for providing a location for this filming.

- Static version of the dashboard is complete. Currently working with vendors to create a live version of similar data.
- Dr. Schlesinger presented through PowerPoint slides various types of reports that can be retrieved from the dashboard which combines data from the LA County's TEMIS system and the Statewide Integrated Traffic Records System (SWITRS). These reports include demographics, crash characteristics, injury area/types, and post-crash care (both prehospital and hospital).

4.8 Health Data Exchange (Chris Clare)

- This is a bi-directional data exchange system between the hospitals and provider agencies. The goal is for the prehospital patient care records to automatically populate into the hospital's patient care record and provider agencies to obtain patient outcome and distinct billing fields (if applicable). This may help with quality improvement and evaluation of care in the field by the providers.
- The EMS Agency is currently working with base hospitals and trauma centers to go live with this project, with an expected implementation date in 2025.

4.9 EMS and Law Enforcement Co-Response (ELCOR) Task Force (Nichole Bosson, MD)

- This taskforce's initial focus was the mental health emergencies and the concern with law enforcement disengagement. As a result of this taskforce, the EMS Agency developed a new Medical Control Guideline and a training PowerPoint, developed by Michael Kim, MD.
- The current plan is to include in EMS Update 2025 a module that describes the best practice for communication between EMS and law enforcement personnel.
- Because of the value of the ELCOR taskforce, this joint taskforce will transition to a formal Committee to establish representation and address various issues between EMS and law enforcement.
- There have been two workgroups formed that are reviewing body cameras worn by law enforcement (led by Denise Whitfield, MD) and response to pediatric critical events (led by Shira Schlesinger, MD).
- Dr. Whitfield described the workgroup's review of the body worn cameras by law enforcement and possible healthcare implications (HIPPA, etc.). As a result, this workgroup developed a reference document that will be posted on the EMS Agency's webpage for EMS provider use.
- Dr. Schlesinger described the workgroup's review of the law enforcement response to pediatric critical events. This workgroup has developed a draft recommendation list of supplies and equipment for law enforcement to carry in their patrol cars and is currently working on developing a script for future training videos.

4.10 ALS Skill Sheets (Denise Whitfield, MD)

- PowerPoint slides were reviewed, showing the EMS Agency's proposed plan for implementing the ALS Skill sheets. There are 12 ALS skills total.
- Skills training would begin during EMS Update 2025, and paramedics would need to complete verification of 6 skills per year, rotating skills every other year.
- The first deadline for completing all 12 ALS skills will be during EMS Update 2027.
- The EMS Agency is currently in discussion with the LA Area Fire Chiefs for final review and approval of this program.
- The point of contact for the training requirements is Jennifer Calderon, Training Program Approvals Section, jrcalderon@dhs.lacounty.gov.

4.11 ECPR Regional System (Nichole Bosson, MD, and Chris Clare)

- The EMS system is continuing ECPR with hospitals who are already ECPR designated and for the providers who are already participating in this program.
- EMS Update 2025 will have a component regarding ECPR and at that time the plan is to change the cardiac arrest destination policy to add ECPR designation.

5. UNFINISHED BUSINESS

None

6. NEW BUSINESS

6.1 EMS Documentation Manual (Sara Rasnake)

- Due to transitioning to the National EMS Information System (NEMSIS), the EMS Documentation Manual has been retired and was replaced with the new LA County EMS NEMSIS Data Dictionary.
- Because there are various electronic patient care record (ePCR) platforms in Los Angeles County, it is important that documentation aligns with each specific provider agency's process. The EMS Agency recommends that each provider agency develop their own documentation manual to be tailored to their own unique ePCR set-up.

6.2 Ad Hoc Committee on the Evaluation of Suicidal Ideation and Behaviors

(Erick Cheung, MD, Psychiatry, UCLA Health / LA County EMS Commissioner)

On behalf of the EMS Commission, Dr. Cheung presented the following information:

- The purpose of this Ad Hoc Committee's was to evaluate the current state of EMS field evaluation and disposition of individuals with suicidal ideation and behaviors, and then to propose recommendations for improving policies, practices, and training.
- Dr. Cheung reviewed the progress of this Ad Hoc Committee including results of a survey that was distributed to LA County EMTs, paramedics and MICNs. From this survey, it was concluded that encounters for suicide risk are common, current protocols/resources are limited and there's a need for more guidance in our system.
- A draft Medical Control Guideline (Evaluation and Care of Patients at Risk of Suicide) was reviewed and included recommendations from the Ad Hoc Committee.
- PAAC members voiced opposition to the draft Medical Control Guideline, including the use of the Columbia Suicide Severity Rating Scale (C-SSRS), and the disposition of high risk and low risk patients.
- Further revisions are pending and will be brought back to this Committee in the future.

Policies for Discussion; Action Required:

6.3 Reference No. 411, Provider Agency Medical Director (David Wells)

Policy reviewed and approved as written.

M/S/C (Kazan/Davis) Approved: Reference No. 411, Provider Agency Medical Director

6.4 Reference No. 420, Private Ambulance Operator Medical Director (David Wells)

Policy reviewed and approved as written.

M/S/C (Kazan/Van Slyke) Approved: Reference No. 420, Private Ambulance Operator Medical Director

6.5 Reference No. 702, Controlled Drugs Carried on ALS Units (David Wells)

Policy reviewed and approved with the following recommendation:

- Replace the lists of individual personnel with the words "ALS personnel" in the following sections: Section III. B; Section III. E. 1.; and Section III. E. 3.

M/S/C (Tucker/Kazan) Approved: Reference No. 702, Controlled Drugs Carried on ALS Units, with recommendation.

6.6 Reference No. 817, Regional Mobile Response Teams (Nichole Bosson, MD)

Policy reviewed and approved as written.

M/S/C (Van Slyke/Kazan) Approve: Reference No. 817, Regional Mobile Response Teams

6.7 Reference No. 519, Management of Multiple Casualty Incidents (Denise Whitfield, MD)

After lengthy review and discussion, this policy was tabled until additional revisions are completed by the

EMS Agency.

TABLED: Reference No. 519, Management of Multiple Casualty Incidents

Due to time restraints the following policies will resume discussion at the next Committee meeting on December 18, 2024:

Policies for discussion; No Action required:

6.8 Reference No. 1202.2, Treatment Protocol: Base Contact Requirements (Denise Whitfield, MD)

6.9 Reference No. 1209/1209-P, Behavioral / Psychiatric Crisis (Nichole Bosson, MD and Denise Whitfield, MD)

7. OPEN DISCUSSION

Deferred until next Committee meeting.

8. NEXT MEETING - December 18, 2024

9. ADJOURNMENT - Meeting adjourned at 3:10 p.m.

SUBJECT: **MANAGEMENT OF MULTIPLE
CASUALTY INCIDENTS**

PURPOSE: To provide guidelines for the efficient management of multiple casualty incidents (MCI) through coordination between prehospital care personnel, receiving facilities, and the Medical Alert Center (MAC) to allow for maximum resource allocation, patient distribution, and to prevent unnecessary delays in patient care and transport.

To provide guidelines for transition from a MCI response to a Mass Casualty Incident Management Response.

This policy defines the roles of the provider agency, MAC, base hospital, and receiving facilities during an MCI.

DEFINITIONS : Refer to Ref. No. 519.1, Multiple Casualty Incidents (MCI) – Definitions.

PRINCIPLES:

1. The Incident Command System (ICS) should be utilized at all MCI's.
2. Terminology is standardized.
3. Expedient and accurate documentation is essential.
4. The MAC is equipped to communicate with multiple receiving facilities simultaneously and can rapidly assess system wide emergency department bed status, hospital, and ambulance resources.
5. Request for hospital diversion status should be considered when determining patient destination; however, if appropriate, patients may be directed to hospitals requesting diversion (Exception: Internal Disaster).
6. Patients requiring Advanced Life Support (ALS) treatment or procedures should be transported by paramedics whenever possible; however, these patients may be transported by Basic Life Support (BLS) units based on available resources during the MCI. BLS units may transport to other than the Most Accessible Receiving (MAR) facility if the patient meets specialty care center criteria and based on available system resources.
7. The EMS Agency will facilitate a post-incident debriefing of large scale incidents to include all affected agencies.
8. To maintain system readiness, provider agencies, hospitals, MAC, and other disaster response teams should carry out regularly scheduled MCI, disaster drills, and monthly VMED28 radio checks.

EFFECTIVE: 05-01-92
REVISED: 04-01-24
SUPERSEDES: 12-01-23

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APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

9. On any MCI in which the need for air transport is identified, early notification to air operations providers is essential in order to ensure rapid access to medical care and preserve life. Air transport should be reserved for immediate patients whose transport destination is greater than can be achieved quickly by available ground ambulances.

POLICY:

I. Role of the Provider Agency

- A. Institute ICS as necessary.
- B. Implement MCI Triage Guidelines (modified START & Jump START) as necessary (see Ref. No. 519.2, MCI Triage Guidelines).
- C. Establish early communication with the:
 - 1. MAC, ~~(via VMED28 when possible)~~ to support incident management;
 - 2. Base hospital, if indicated, for the purpose of medical direction and/or patient destination. ~~although it is acknowledged that there may be field circumstances that limit the feasibility of Base Contact, including when BLS transport is used. In these cases, notify the receiving hospital whenever possible.~~
 - 3. Receiving hospital, when time/resources allow, for ALS patients when Base contact is not indicated in order to provide pertinent patient clinical information.
- D. If the need for additional ALS and/or BLS transport units exceeds the jurisdictional provider agency's capability, additional transport resources may be requested by the jurisdictional dispatch center or the Fire Operational Area Coordinator (FOAC) as per Ref. No. 519.3, Multiple Casualty Incident Transportation Management.
- E. Request hospital based medical resources (i.e., HERT) from the MAC as outlined in Ref. No. 817, Regional Mobile Response Team if necessary.
- F. Provide the following scene information to the MAC:
 - 1. Nature of incident
 - 2. Location of incident
 - 3. Medical Communications Coordinator (Med Com) provider unit and agency
 - 4. Agency in charge of incident
 - 5. Total number of estimated immediate, delayed, minor and deceased patients. If indicated, include total number and category of pediatric

-
- patients
 - 6. Nearest receiving facilities including trauma centers, PMCs, PTCs, and EDAPs
 - 7. Transporting provider, unit number, and destination
 - 8. Type of hazardous material, contamination, level of decontamination completed, if indicated
 - 9. Name of law enforcement agency on scene if involved in patient care and/or transportation
 - G. Document the following patient information on the appropriate Patient Care Record:
 - 1. Patient name
 - 2. Chief complaint
 - 3. Triage category
 - 4. Mechanism of injury
 - 5. Age
 - 6. Sex
 - 7. Brief patient assessment
 - 8. Brief description of treatment provided
 - 9. Sequence number
 - 10. Transporting provider, unit number, and destination
 - H. Reassess situational status to identify available resources and resource needs. If the anticipated resource needs exceed available local and mutual aid resources, contact the FOAC. Additional resources beyond the operational area shall be requested through the Regional Disaster Medical and Health Coordinator (RDMHC) via the MAC.
 - C. Whenever departmental resources allow, the EMS provider agency should consider assigning a provider agency representative to report to the MAC to assist with communications and coordination of patient destination.
- II. Role of the MAC
- A. Provide prehospital care personnel with emergency department bed availability and diversion status as indicated by the ReddiNet poll.

- B. Arrange for additional ambulance transport units as requested by the FOAC or RDMHC.
 - C. Coordinate activation of Regional Mobile Response Teams as requested.
 - D. Coordinate Air ambulance resources.
 - E. Notify receiving facilities of incoming patients immediately via the ReddiNet®.
 - F. Document, under the authority of the EMS Administrator on Duty (AOD) lifting of trauma catchment and service areas.
 - G. Maintain an “open MCI victim list” via the ReddiNet® for 72 hours.
 - H. Complete a written report to include a summary of the incident and final disposition of all patients involved as indicated.
 - I. Notify the EMS AOD and Medical Officer on Duty (MOD) per MAC policies and procedures.
 - J. The EMS Agency, as the Medical and Health Operational Area Coordinator (MHOAC) for the County of Los Angeles, will assess the situational status and evaluate available resources and resource needs. If the anticipated resource needs exceed the available resources the EMS Agency, via its role as the RDMHC, will request resources from surrounding counties.
 - K. Maintain an EMS provider agency Medical/Health Resource Directory and assist EMS providers with MCI resource management when requested.
- III. Role of the Base Hospital
- A. Provide EMS personnel with emergency department bed availability and diversion status.
 - B. Assist EMS personnel as needed with patient destination.
 - C. Provide medical direction as needed.
 - D. Notify receiving facilities of incoming patients.
- IV. Role of the Receiving Facility
- A. Provide the MAC or base hospital with emergency department bed availability upon request.
 - B. Trauma Centers are automatically designated to accept 20 Immediate patients (adult and pediatric) from MCIs, if needed MAC will distribute patients systemwide based on the incident.

- C. When activated by the EMS Agency, Burn Resource Centers (BRC) can accept up to 20 critically burned patients (includes both adult and pediatric).
- D. Accept MCI patients as directed by the MAC or base hospital.
- E. Monitor ~~the~~ VMED 28 and ReddiNet®, recognizing that these are the default methods for MCI communications since Base Contact and/or notification may not be feasible when field resources are limited.
- E.F. Provide the MAC or base hospital with patient disposition information, sequence numbers, and/or triage tags when requested and enter information into the ReddiNet®.
- E.G. Maintain the “Receiving Facility” copy of the Patient Care Record and/or triage tag as part of the patient’s medical record.
- E.H. Ensure that requested patient information is entered as soon as possible into the ReddiNet® “MCI victim list” for all patients received from the MCI. The “MCI victim list” will remain open for 72 hours after the incident.
- E.I. Notify the MAC if resource needs exceed available resources.

CROSS REFERENCE:

Prehospital Care Manual:

- Ref. No. 201, **Medical Direction of Prehospital Care**
- Ref. No. 502, **Patient Destination**
- Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
- Ref. No. 506, **Trauma Triage**
- Ref. No. 510 **Pediatric Patient Destination**
- Ref. No. 511, **Perinatal Patient Destination**
- Ref. No. 519.1, **MCI Definitions**
- Ref. No. 519.2, **MCI Triage Guidelines**
- Ref. No. 519.3, **Multiple Casualty Incident Transportation Management**
- Ref. No. 519.4, **MCI Transport Priority Guidelines**
- Ref. No. 519.5, **MCI Field Decontamination Guidelines**
- Ref. No. 519.6, **Regional MCI Maps and Bed Availability Worksheets**
- Ref. No. 803, **Paramedic Scope of Practice**
- Ref. No. 807, **Medical Control during Hazardous Material Exposure**
- Ref. No. 814, **Determination/Pronouncement of Death**
- Ref. No. 817, **Regional Mobile Response Team**
- Ref. No. 842, **Mass Gathering Interface with Emergency Medical Services**

FIRESCOPE’s Field Operations Guide ICS 420-1. December 2012

PRINCIPLES:

1. Base Contact is made by paramedics to establish online medical direction for additional guidance on field care beyond what is contained in the offline treatment protocols.
2. Once the patient is no longer present and under the care of the paramedic medical direction is not needed. Therefore, this policy does not apply and Base Contact is not required.
3. Base Contact for all patients shall be made according to the requirements below and at the judgment of the treating paramedic. Access to online medical direction is not limited to those conditions listed below.
4. For children 13 to 36 months of age, Base Contact and/or transport is required, except those with no medical complaint or with isolated minor extremity injury.
5. Children less than or equal to 12 months of age must be transported in accordance with [Ref. No. 510](#), regardless of provider impression or field treatment rendered, and if a parent or caregiver refuses transport, Base Contact shall be made prior to signing the patient out Against Medical Advice (AMA).
6. Base Contact criteria below still apply if the patient is on scene and refusing transport (AMA). This includes parents or legal guardians who refuse transport of a pediatric patient.
7. This document provides a quick reference list for Base Contact requirements; it does not replace the treatment protocols or the guidance there within, which shall be followed at all times unless otherwise directed by online medical direction.

GUIDELINES:

1. Base Contact is required when consultation with the base would be helpful such as:
 - a. Patient presentation renders the provider impression and appropriate treatment protocol unclear
 - b. Additional or unlisted treatments are required
- ~~2. Base Contact is required when five or more patients require transport (contacting the Medical Alert Center constitutes Base Contact).~~
3. Base Contact is required for children who meet transport guidelines to a Pediatric Medical Center ([Ref. 510](#))
4. Base Contact is required for patients in traumatic full arrest who do not meet criteria for determination of death per [Ref. 814](#). In these instances, Base Contact shall be made with the Trauma Center.
5. Base Contact is required for the following provider impressions in all patients:

- a. Agitated Delirium
 - b. Anaphylaxis
 - c. Cardiac Arrest – Non-traumatic (unless patient meets determination of death by Ref. 814)
 - d. Childbirth
 - e. Dystonic Reaction
 - f. Hypotension
 - g. Respiratory Failure
 - h. Shock
 - i. Stroke / CVA / TIA
6. Additionally, Base Contact is required for the following provider impressions in pediatric patients:
- a. BRUE
 - b. Chest Pain – Suspected Cardiac / Chest Pain - STEMI
 - c. Pregnancy/Labor
 - d. Newborn
7. Base Contact is required for the following provider impressions under the specified conditions:
- a. Airway Obstruction
 - Severe respiratory distress or respiratory arrest
 - b. Altered Level of Consciousness (ALOC)
 - Persistent ALOC of unclear etiology
 - c. Cardiac Dysrhythmia
 - Rapid atrial fibrillation with poor perfusion
 - Symptomatic bradycardia
 - Wide complex tachycardia
 - d. Medical Device Malfunction
 - Ventricular Assist Device (VAD) malfunction
 - e. Overdose / Poisoning / Ingestion
 - If signing out AMA
 - f. Pregnancy Complication

- >20 weeks with vaginal bleeding
 - g. Respiratory Distress (of any etiology e.g. Bronchospasm, Pulmonary Edema, Other)
 - Severe respiratory distress unresponsive or not amenable to CPAP
 - Unmanageable airway
 - h. Seizure
 - Pregnant patient
 - Status epilepticus
 - i. Submersion / Drowning
 - ALOC
 - Decompression illness
 - j. Traumatic Injury
 - Crush syndrome
 - Prolonged entrapment >30 minutes
 - Trauma criteria or guidelines met
 - Traumatic arrest not meeting criteria for determination of death per Ref. 814
8. Base Contact is required concurrently when the following treatments are initiated:
- a. Adenosine in pediatric patients
 - b. Cardioversion
 - c. Push-dose epinephrine
 - d. Transcutaneous pacing
9. Base Contact is required prior to initiating the following treatments:
- a. Additional dosing of normal saline or medications (e.g., midazolam, opiate analgesia) after the maximum dose is administered per protocol
 - b. Calcium chloride for patients with calcium channel blocker overdose
 - c. Cardioversion of a patient with adequate perfusion, or awake with a narrow complex tachycardia, or any atrial fibrillation
 - d. Midazolam for treatment of agitation in a patient with behavioral/psychiatric crisis
 - e. IO placement beyond the indications listed in [MCG 1375](#)
 - f. Sodium bicarbonate for symptomatic bradycardia with suspected hyperkalemia or for dysrhythmia due to possible tricyclic antidepressant or other toxic overdose
 - g. Transcutaneous pacing if HR >40

Base Hospital Contact: Required for all patients with severe agitation with ALOC.

1. Perform initial assessment of scene and patient situation for safety **1**
2. Attain law enforcement (LE) assistance prior to approaching a patient if a weapon is visualized or the patient threatens violence or for potential assistance with application of an involuntary psychiatric hold **1 2**
3. Approach patient with caution, assess for agitation and ~~treat accordingly including~~ use of verbal de-escalation as needed (*MCG 1307, Care of the Psychiatric Patient with Agitation*) **3**
4. Evaluate for medical conditions, including those that may present with psychiatric features **4**
- 4.5. ~~Assess airway and~~ initiate basic and/or advanced airway maneuvers prn
6. Administer **Oxygen** prn (*MCG 1302*)
- 5.7. Apply physical restraints when indicated (*Ref. No. 838, Application of Patient Restraints*) **5**
6. ~~Assess for agitated delirium; treat per TP 1208, Agitated Delirium~~
7. ~~Evaluate for medical conditions, including those that may present with psychiatric features~~ **4**
8. Manage ongoing agitation based on patient's condition
- 8.9. ~~For~~ ongoing agitation and the patient is COOPERATIVE PATIENTS:

Olanzapine 10mg Oral Disintegrating Tablet (ODT); given once (*MCG 1317.32*) **5 6**

~~If ongoing agitation with safety risk to patient or EMS personnel~~ **CONTACT BASE** for orders for treatment of agitation:

Midazolam 5mg (1mL) IM/IN/IV, repeat every 5 min prn

~~With Base orders may repeat as above up to a maximum total dose of 20mg~~ **6 7**

10. For UNCOOPERATIVE PATIENTS who pose a POTENTIAL SAFETY RISK to self and/or EMS personnel:

CONTACT BASE

Consider **Midazolam 5mg (1mL) IM/IN/IV**, with Base orders may repeat every 5 min prn to a maximum total dose of 20mg **6 7**

11. For SEVERE AGITATION WITH ALOC who pose an IMMEDIATE RISK to self and/or EMS personnel:

Administer **Midazolam 5mg (1mL) IM/IN/IV**

Repeat x1 in 5 min prn, maximum total dose of prior to Base Contact 10mg **6 7**

CONTACT BASE for additional sedation

With Base orders may repeat as above up to a maximum total dose of 20mg ^{6 7}

Normal Saline 1L IV rapid infusion

Reassess after each 250mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

12. Initiate cardiac monitoring prn, including all patients in restraint and/or post-sedation (MCG 1308)

^{6 8}

Monitor ventilations and assess for dysrhythmia or interval widening

CONTACT BASE for QRS > 0.12 sec or heart rate < 50 to discuss need to administer **Sodium Bicarbonate 50mEq (50mL) IV** ^{9 10}

13. If patient's skin is hot to touch or has a measured fever with suspected hyperthermia (i.e., measured temperature greater than 39C or 102F), initiate cooling measures

14. Establish vascular access prn (MCG 1375)

Check blood glucose prn ^{10 9 8}

If glucose < 60 mg/dL or > 400 mg/dL treat in conjunction with TP 1203, Diabetic Emergencies

9. Evaluate for physical trauma; if present treat in conjunction with TP 1244, Traumatic Injury

15.

~~10.1. Establish vascular access prn (MCG 1375)~~

~~Check blood glucose prn ⁹~~

~~If glucose < 60 mg/dL or > 400 mg/dL treat in conjunction with TP 1203, Diabetic Emergencies~~

~~11. Initiate cardiac monitoring prn (MCG 1308)~~

~~Assess for dysrhythmia or interval widening~~

~~**CONTACT BASE** for QRS > 0.12 sec or heart rate < 50 to discuss need to administer **Sodium Bicarbonate 50mEq (50mL) IV** ⁹~~

12.16. Evaluate for possible suicide attempt ^{11 10}

For potential overdose, obtain patient and bystanders information about ingestions and treat in conjunction with TP 1241, Overdose/Poisoning/Ingestion

13.17. Evaluate for acute mental health and/or substance abuse crises

Obtain relevant clinical history regarding patient's current psychiatric diagnoses, psychiatric and other medications, and any recent alcohol or recreational drug ingestions

Obtain and document relevant third party or collateral data ^{12 11}

14.18. Patients who respond to verbal de-escalation or are treated only with olanzapine for agitation, and are now cooperative, and who meet criteria in Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination and Ref. 526.1 Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center, may be transported by Basic Life Support (BLS) or law enforcement (LE) to the MAR or to a Psychiatric Urgent Care Center.

15.19. Patients, evaluated by EMS personnel not yet approved for alternate destination transport,

who receive olanzapine for agitation and are otherwise stable, and do not have an emergency medical condition, may be transported by BLS or law enforcement to the MAR only.

SPECIAL CONSIDERATIONS

- ① Scene safety includes the assessment for the presence of firearms or weapons, including observations and direct inquiry with the patient and any available/relevant third parties (e.g., family, caregivers, or witnesses). If a weapon is found on the scene, EMS personnel should notify all members on the scene, and contact law enforcement (LE) immediately.
- ② Psychiatric, including mental health and substance abuse, emergencies are medical emergencies, and as such are best treated by EMS personnel. Those patients with psychiatric emergencies presenting with agitation, violence, threats of harm to self or others, or criminal activity are best managed by an EMS and LE co-response.
- ③ Always attempt verbal de-escalation first and avoid applying restraints to patients who do not present a threat to self or EMS personnel (*Ref. No. 838, Application of Patient Restraints*)
- ④ Many medical causes of psychiatric symptoms exist:
 - Agitation (*see MCG 1307*)
 - Acute pain
 - Head trauma
 - Infection
 - Encephalitis or Encephalopathy
 - Exposure to environmental toxins
 - Metabolic derangement
 - Hypoxia
 - Thyroid disease or other hormone irregularity
 - Neurological disease
 - Toxic levels of medications
 - Alcohol or recreational drugs: intoxication or withdrawal
 - Exacerbation of a primary psychiatric illness
 - Autism Spectrum Disorder
 - Psychosis
 - Delirium
 - Chronic neurological disease (dementia, seizures, parkinsonism, brain tumor)
 - Steroid use, other medication reactions
 - Alcohol or recreational drugs: intoxication or withdrawal
 - Mania
 - Delirium
 - Thyrotoxicosis
 - Alcohol or recreational drugs: intoxication or withdrawal
 - Anxiety
 - Respiratory disease
 - Cardiac disease
 - Thyroid disease
 - Toxic levels of medications
 - Alcohol or recreational drugs: intoxication or withdrawal
 - Depression
 - Reaction to medication
 - Chronic disease or chronic pain

Hormonal variations
Subclinical / clinical hypothyroidism
Alcohol or recreational drugs: intoxication or withdrawal

- 5 Use of restraints in severely agitated patients is associated with an increased risk of sudden death. Avoid using restraints in patients who do not present a threat to self or to EMS personnel. Monitor patients closely when restraints are applied. Never secure or transport a patient in restraints in prone position.

~~Olanzapine onset is 10-15 minutes with maximum effect at 45-60 minutes~~

- 6 Medications used for pharmacologic management of agitation may cause respiratory depression; administer only when necessary for the safety of the patients and/or EMS Personnel., and ~~e~~Every individual who receives restraint and/or midazolam pharmacologic management should be continuously monitored and transported for additional clinical assessment and treatment.
- 7 ~~Midazolam onset is 2 minutes with maximum effect at 5 minutes.~~ The IM or IN route is preferred unless an IV has been previously established.
- 8 Patients who are agitated while in physical restraint and have the potential for injury due to the degree of agitation, should receive medication by EMS personnel to reduce agitation with continued monitoring for respiratory depression, in accordance with Ref 838. Application of Patient Restraints.
- 9 Several drugs that may cause agitation and present similarly to a psychiatric crisis may also cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged QRS intervals (> 0.12 sec) or bradycardia. Cocaine intoxication is strongly associated with severe agitation. Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discussion administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with TP 1241, Overdose / Poisoning / Ingestion. ~~Agitation may be present after a seizure, or in the setting of hypo/hypoglycemia. Consider checking glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so.~~
- 10.9 Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so.

~~Several drugs that may cause agitation and present similarly to a psychiatric crisis may also cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged QRS intervals (> 0.12 sec) or bradycardia. Cocaine intoxication is strongly associated with Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discussion administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with TP 1241, Overdose /~~

~~Poisoning / Ingestion~~

- 11.10 It is important to assess for any evidence of suicide attempt. If there is concern for overdose, ask the patient or bystanders to provide information on agents used (specifically what, when, and how much). Collect and transport any medication vials, or additional pills). This will assist in determining necessary antidote treatment and monitoring at the hospital. This information is often lost, if not obtained immediately on scene.

- 11.12 Patients with acute mental health or substance abuse crises may not be capable or willing to provide reliable information; therefore, it is important to obtain third party collateral information about the patient's condition (e.g., from family, caregivers, witnesses), including names and contact information for persons knowledgeable about the patient's illness, treatment and medications.



Base Hospital Contact: Required for all patients with severe agitation with ALOC.

1. Perform initial assessment of scene and patient situation for safety **1**
2. Attain law enforcement (LE) assistance ~~for assistance~~ prior to approaching a patient if a weapon is visualized or the patient threatens violence or for potential assistance with application of an involuntary psychiatric hold **1 2**
3. Approach patient with caution, assess ~~for~~ agitation and ~~treat accordingly including~~ use of verbal de-escalation as needed (MCG 1307, Care of the Psychiatric Patient with Agitation) **3**
4. Evaluate for medical conditions, including those that may present with psychiatric features **4**
- ~~4.5. Assess airway and initiate~~ basic and/or advanced airway maneuvers prn
- ~~5.6. Administer~~ **Oxygen** prn (MCG 1302)
7. Apply physical restraints when indicated (Ref. No. 838, Application of Patient Restraints) **5**
8. Manage ongoing agitation based on patient's condition
9. For COOPERATIVE PATIENTS:
Olanzapine 10mg Oral Disintegrating Tablet (ODT); given once for pediatric patients longer than the length-based resuscitation tape per MCG 1309; (MCG 1317.32.) given once
10. For UNCOOPERATIVE PATIENTS who pose a POTENTIAL SAFETY RISK to self and/or EMS personnel:
CONTACT BASE
Consider Midazolam (5mg/mL) 0.2 mg/kg IM/IN, dose per MCG 1309
Repeat every 5 min prn; maximum single dose 5mg
With Base orders may repeat as above to a total maximum dose of 15mg **6 7**
11. For SEVERE AGITATION WITH ALOC who pose an IMMEDIATE RISK to self and/or EMS personnel:
Administer Midazolam (5mg/mL) 0.2 mg/kg IM/IN, dose per MCG 1309
Repeat x1 in 5 min prn, maximum total dose of prior to Base Contact 10mg **6 7**
CONTACT BASE for additional sedation
With Base orders may repeat as above up to a maximum total dose of 15mg **6 7**
Normal Saline 20mg/kg IV rapid infusion per MCG 1309
12. Initiate cardiac monitoring, including all patients in restraint and/or post-sedation prn (MCG 1308) **6 8**
Monitor ventilations and assess for dysrhythmia or interval widening
Assess for dysrhythmia or interval widening



CONTACT BASE for QRS > 0.12 sec or heart rate < 50 to discuss need to administer **Sodium Bicarbonate 1 meq/kg** per **MCG 1309** 9 9

~~13. If patient's skin is hot to touch or has a measured fever with suspected hyperthermia (i.e., measured temperature greater than 39C or 102F), initiate cooling measures~~

~~14. Establish vascular access prn (MCG 1375)~~

~~Check blood glucose prn 10 9~~

~~If glucose < 60 mg/dL or > 250 mg/dL treat in conjunction with TP 1203-P, Diabetic Emergencies~~

~~Assess for agitated delirium; treat per TP 1208-P, Agitated Delirium~~

~~6. Evaluate for acute medical conditions, including those that may present with psychiatric features 4~~

~~7. If ongoing agitation and the patient is cooperative:~~

~~Olanzapine 10mg ODT for pediatric patients longer than the length-based resuscitation tape per MCG 1309; MCG 1317.32; given once 5 6~~

~~8. If ongoing agitation with safety risk to patient or EMS personnel~~

~~CONTACT BASE for orders for treatment of agitation:~~

~~Midazolam (5mg/mL) 0.2 mg/kg IM/IN, dose per MCG 1309~~

~~Repeat every 5 min prn; maximum single dose 5mg~~

~~With Base orders may repeat as above to a total maximum dose of 15mg 6 7~~

~~9. Evaluate for physical trauma; if present treat in conjunction with TP-1244-P, Traumatic Injury~~

~~10. Establish vascular access prn (MCG 1375)~~

~~Check blood glucose prn 9~~

~~If glucose < 60 mg/dL or > 250 mg/dL treat in conjunction with TP 1203 P, Diabetic Emergencies~~

~~15.~~

~~11.1. Initiate cardiac monitoring prn (MCG 1308)~~

~~Assess for dysrhythmia or interval widening~~

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~~12.16. Evaluate for a possible suicide attempt 11 10~~

~~For potential overdose, obtain patient and bystanders information about ingestions and treat in conjunction with TP 1241-P, Overdose/Poisoning/Ingestion~~

~~13.17. Evaluate for acute mental health and/or substance abuse crises~~

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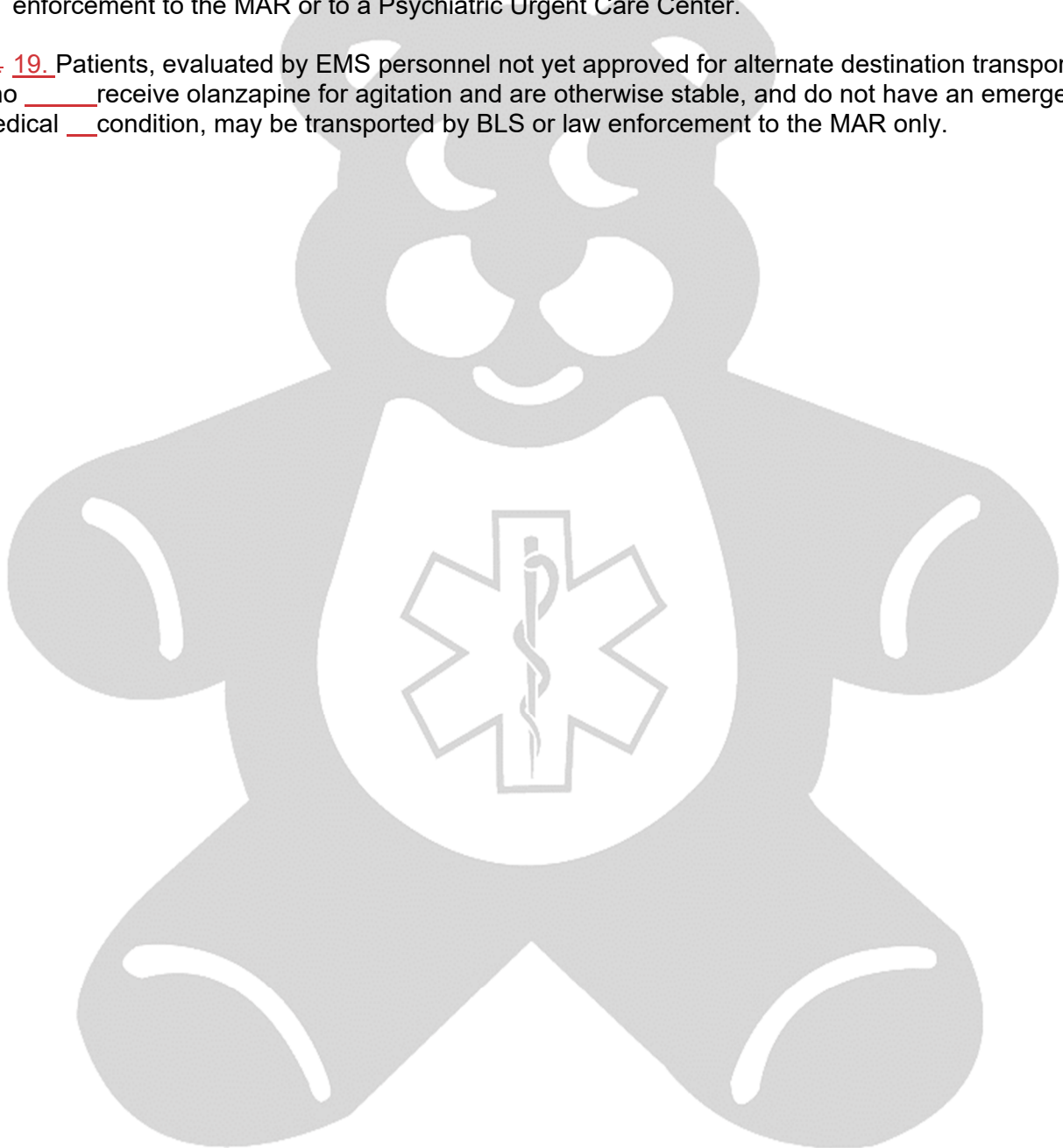
~~185. Patients who respond to verbal de-escalation or are treated only with olanzapine for~~



Treatment Protocol: BEHAVIORAL / PSYCHIATRIC CRISIS **Ref. No. 1209-P**

agitation, and are now cooperative, and who meet criteria in *Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination* and *Ref. No. 526.1 Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center*, may be transported by Basic Life Support (BLS) or law enforcement to the MAR or to a Psychiatric Urgent Care Center.

~~46.~~ 19. Patients, evaluated by EMS personnel not yet approved for alternate destination transport, who _____ receive olanzapine for agitation and are otherwise stable, and do not have an emergency medical ___ condition, may be transported by BLS or law enforcement to the MAR only.





SPECIAL CONSIDERATIONS

- ① Scene safety includes the assessment for the presence of firearms or weapons, including observations and direct inquiry with the patient and any available/relevant third parties (e.g., family, caregivers, or witnesses). If a weapon is found on the scene, EMS personnel should notify all members on the scene, and contact law enforcement (LE) immediately.
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- ③ Always attempt verbal de-escalation first and avoid applying restraints to patients who do not present a threat to self or EMS personnel (*Ref. 838, Application of Patients Restraints*)
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 - Toxic levels of medications
 - Alcohol or recreational drugs: intoxication or withdrawal
 - Depression
 - Reaction to medication
 - Chronic disease or chronic pain
 - Hormonal variations



Subclinical / clinical hypothyroidism

Alcohol or recreational drugs: intoxication or withdrawal

5. Use of restraints in severely agitated patients is associated with an increased risk of sudden death.

Avoid using restraints in patients who do not present a threat to self or to EMS personnel. Monitor patients closely when restraints are applied. Never secure or transport a patient in restraints in prone position.

~~Olanzapine onset is 10-15 minutes with maximum effect at 45-60 minutes.~~

6. Medications used for pharmacologic management of agitation may cause respiratory depression; administer only when necessary for the safety of the patients and/or EMS Personnel. Every individual who receives restraint and/or midazolam pharmacologic management should be continuously monitored and transported for additional clinical assessment and treatment. used for pharmacologic management of agitation may cause respiratory depression, and

~~— every individual who receives pharmacologic management should be continuously monitored and — transported for additional clinical assessment and treatment.~~

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9. Several drugs that may cause agitation and present similarly to a psychiatric crisis may also cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged QRS intervals (> 0.12 sec) or bradycardia. Cocaine intoxication is strongly associated with severe agitation and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discussion administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with TP 1241-P, Overdose / Poisoning / Ingestion

~~Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so.~~

10. Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking

glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so. Several drugs that may cause agitation and present similarly to a psychiatric crisis may also cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged QRS intervals (> 0.12 sec) or bradycardia. Cocaine intoxication is strongly associated with Agitated Delirium and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant



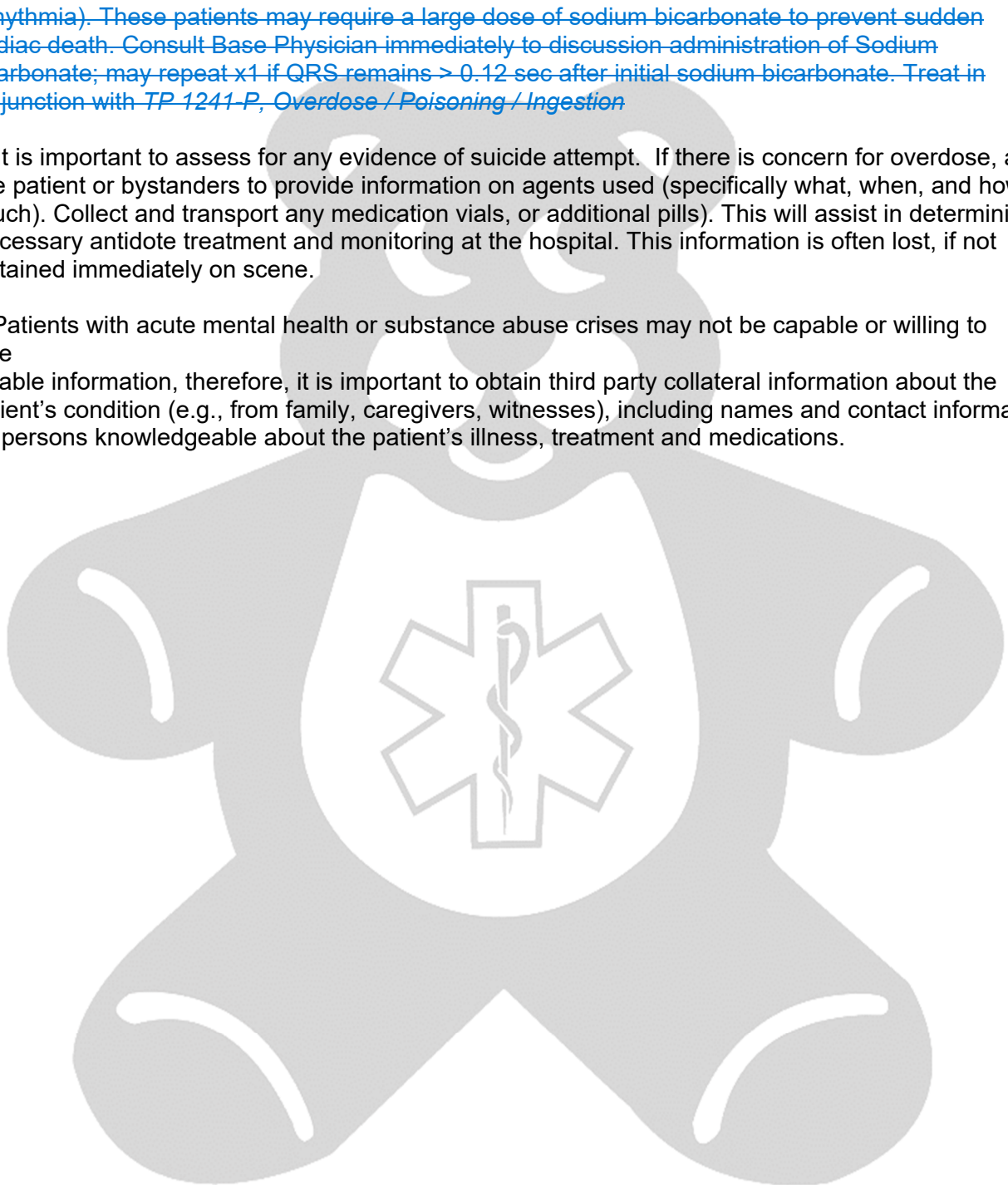
Treatment Protocol: BEHAVIORAL / PSYCHIATRIC CRISIS

Ref. No. 1209-P

~~arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discussion administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with TP 1241-P, Overdose / Poisoning / Ingestion~~

11.19 It is important to assess for any evidence of suicide attempt. If there is concern for overdose, ask the patient or bystanders to provide information on agents used (specifically what, when, and how much). Collect and transport any medication vials, or additional pills). This will assist in determining necessary antidote treatment and monitoring at the hospital. This information is often lost, if not obtained immediately on scene.

12.11 Patients with acute mental health or substance abuse crises may not be capable or willing to provide reliable information, therefore, it is important to obtain third party collateral information about the patient's condition (e.g., from family, caregivers, witnesses), including names and contact information for persons knowledgeable about the patient's illness, treatment and medications.



Los Angeles County
Pediatric Acute Surge Plan



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

Effective: May 2013

Last Edited: ~~November 2022~~ August 2024

Director, EMS Agency

Medical Director, EMS Agency



Medical Director, EMS Agency

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For more information, please consult the following points of contact (POC):

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Los Angeles County Emergency Medical Services Agency
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EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Pediatric Acute Surge Plan

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Los Angeles County Department of Health Services (DHS) Emergency Medical Services (EMS) Agency Pediatric Acute Surge Plan

The goal of ~~this~~ ~~the Pediatric~~ Pediatric Acute Surge plan is to double the County of Los Angeles County's (LAC) collective inpatient pediatric capacity. ~~Given the variability in pediatric care on a daily basis, a~~ All hospitals are requested to plan for an event resulting in an acute surge of pediatric patients. The definition of acute surge of patients is a sudden and substantial increase in the number of patients requiring medical attention within a short time frame, typically due to an acute event such as a mass casualty incident (MCI). This plan is founded on a tiered system based on pediatric emergency care resources and pediatric inpatient capacity and capability. Therefore, patient age and acuity need to be considered when determining the location where children will be treated. The goal is to expand hospitals' existing capabilities and triage the most critically ill or injured children to those hospitals accustomed to treating them. Although hospital capabilities and capacity vary, all hospitals will need to participate to meet the needs of children.

Activation & Notification

The ~~LAC-EMS Agency Pediatric Surge Plan~~ Pediatric Acute Surge Plan may be activated in response to an event that has a disproportionate or large number of pediatric patients in which the need exceeds the day-to-day available resources. This plan will be activated by in the same manner in which the ~~LAC-EMS Agency functions on a daily basis~~ through the use of ReddiNet® and transfers through the EMS Agency Medical Alert Center (MAC). The EMS Agency will be responsible for activating the plan based upon the information they receive about a given incident.

The MAC will notify all hospitals and prehospital providers that the ~~Pediatric Surge Plan~~ Pediatric Acute Surge Plan has been activated through the ReddiNet® messaging module. Pre-notification, based on events leading up to the acute surge, may be provided at the discretion of the MAC and Medical Officer on Duty (MOD). Bed availability and facility assessment polls may be issued to determine activation.

Operations

LAC EMS Agency

- The Los Angeles County Department of Health Services Emergency Medical Services (EMS) Agency Department Operations Center (DOC) Medical Coordination Center (MCC), as the Medical and Health Operational Area Coordinator (MHOAC), will monitor hospital bed availability and coordinate the distribution of pediatric patients within the County's healthcare system using the ~~pediatric surge plan~~ Pediatric Acute Surge Plan as a guide to where patients should go and how many patients hospitals have agreed to accommodate.
- To facilitate the distribution of pediatric patients, the MCC will coordinate transportation and destination of prehospital patients, facilitate interfacility transfers, as needed, and waive the requirements for Reference No. 510, Pediatric Patient

Destination, as applicable.

- ~~The MAC will notify all hospitals and prehospital providers that the Pediatric Surge Plan Pediatric Acute Surge Plan has been activated through the ReddiNet® messaging module.~~
- Patients shall be distributed to an appropriate level of care given the specific circumstances of the situation, a trauma versus a medical event. The tiers provide general guidelines that may be used in a surge that disproportionately affects children as a method for supporting the distribution of patients throughout the County. ~~It may be necessary to consult a pediatric medical expert in the triage and distribution of patients when operationalizing this plan~~ (Figure 1, an overview of patient distribution by tier).
- ~~The type of event, regional resource capability, and current burden of acute care~~ will be taken into account by LAC EMS Agency when coordinating
- patient distribution with prehospital providers.
 - a. **Trauma event:** ~~The LAC EMS Agency MCC~~ ~~and~~ the Medical Alert Center (MAC) will utilize LAC pediatric trauma centers (PTC) for the youngest and most traumatically injured pediatric patients.
 - b. **Medical event:** ~~The MCC LAC EMS Agency and or~~ the ~~Medical Alert center~~ MAC will utilize LAC pediatric medical centers (PMC) for the youngest and most critically ill pediatric patients.

Hospitals

- To expand the hospital's existing capability, each individual hospital will determine what specific strategies to implement to meet their surge capacity target. For reference, surge strategies are provided in **Appendix G-ED** of this document.
- Hospitals will utilize the clinical practices of pediatric care ~~and/or the "Los Angeles County Pediatric Readiness Project" (PRP) to develop and maintain a plan that meets the needs to the hospital's tier role. See <https://lapedsready.org/>~~ ~~and/or the "Los Angeles County Pediatric Readiness Project" (PRP) that are standard for available their facility. at <https://lapedsready.org/>~~
- If an interfacility transfer ~~is required~~ ~~needs to occur, due to the need~~ for a higher or lower level of care, the hospital will need to contact the ~~DOC-MCC~~ to coordinate the transfer.
- All communication regarding plan activation, resource requests, and patient transfers will utilize the ~~MCC for~~ everyday systems and procedures ~~in place~~.

Prehospital Providers

- ~~The Medical Alert Center will notify prehospital providers that the Pediatric Surge Plan Pediatric Acute Surge Plan has been activated.~~
- Providers will continue to work with the ~~DOC-MCC~~ through standard operating procedures to distribute patients.
 - o The ~~DOC-MCC~~ will take into account the activation of the ~~Pediatric Surge Plan Pediatric Acute Surge Plan~~ and will provide hospital destination information by utilizing the tiered guidelines.

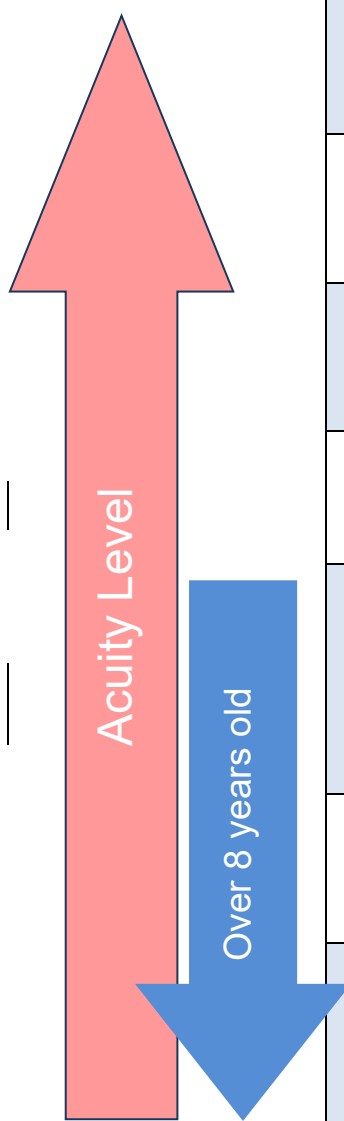
Deactivation

As the LAC ~~DOC-MCC~~ monitors hospital bed availability and coordinates the distribution of pediatric patients, they will determine ~~that the~~ when the pediatric surge has concluded ~~when all pediatric patients who require inpatient hospitalization are admitted to are-~~ ~~hospitalized in appropriate Tier 1-4 facilities.~~ ~~There may be a need to transition into additional surge plans should the need arise.~~ The LAC ~~DOC-MCC~~ will then take the appropriate steps to deactivate ~~this the Pediatric Surge Plan~~ ~~Pediatric Acute Surge Plan~~, ~~involving to include:~~

- ~~Notifying~~ ~~ication~~ ~~all necessary hospitals and prehospital providers in Los Angeles County~~ via ReddiNet® of the conclusion of the pediatric surge ~~to all necessary hospitals and healthcare facilities~~ ~~prehospital providers in Los Angeles County.~~
- Reinstating ~~ing~~ Reference No. 510, Pediatric Patient Destination, as applicable.

Figure 1 - Overview of Patient Distribution by Tier

* Note: In a pediatric trauma surge event, patients would go to Tier 3 before Tier 2



HOSPITAL TIER	TIER DESCRIPTION
Tier 1	Pediatric Centers (PTC/PMC)
Tier 2*	Pediatric Medical Centers (PMC)
Tier 3	Adult Trauma Centers
Tier 4	Pediatric Acute <u>Inpatient</u> Beds
Tier 5	Emergency Department Approved for Pediatrics (EDAP) <u>do not provide inpatient pediatric services</u>
Tier 6	No Pediatric Services
Tier 7	No Emergency Services/ Specialty Centers

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Appendix A

Translating Triage to Tiers: Tool for the LAG EMS Agency Medical Alert Center

Translating Disaster Triage to Tier

Disaster Triage Categories to Tiers (Trauma Event)

The following table is a visual representation of the suggested triage categories to be distributed to each tier in the event of a Pediatric TRAUMA surge event that has a disproportionate number of pediatric victims. **Use of the LA County Trauma system would be used first**

		Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	Tier 7
<u>Triage Category</u>	<u>Age</u>							
Immediate	<8 yrs	X						
Immediate	>8 yrs	X		X				
Delayed	<8 yrs	X	X		X	X		
Delayed	>8 yrs			X	X	X	X	Transfer patients
Minor	All				X	X	X	

Legend

- Facilities have resources to handle and should be PRIORITIZED to receive these types of patients.
- Facilities have resources to handle these types of patients but should be utilized for their priority patients first.
- Facilities are accustomed to handling patients other than this type.

This figure was created as a guide based on feedback during the exercise. Triage categories are used on a routine basis for prehospital providers, whereas the use of a tiered system for the pediatric surge is not. The figure is intended to support the understanding of how the pediatric surge tiers correspond to triage categories.

Distribution of Patients to Tiers (Medical Event)

The following table is a visual representation of the suggested age categories to be distributed to each tier in the event of a MEDICAL surge event that has a disproportionate number of pediatric victims:

	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	Tier 7
Age							
>under or equal 8 yrs	<u>X</u>	<u>X</u>		<u>X</u>			
>over or 8 yrs	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>Transfer patients</u>



Legend

- Facilities have resources to handle and should be **PRIORITIZED** to receive these types of patients.
- Facilities have resources to handle these types of patients but should be utilized for their priority patients first.
- Facilities are accustomed to handling patients other than this type.



Appendix B

Tier Capability and Surge Capacity

Overview

The below table is a high-level overview of the pediatric surge plan including the tiers, tier-criteria, types of patients, and proposed surge approach. **Appendix A** lists the hospitals that comprise each tier.

Tier Definition	Tier Criteria	Types of Patients Recommended for the Tier	Proposed Surge Strategy
<p><u>1 Tier 1 Hospitals are those facilities that currently care for pediatric intensive care, pediatric acute care, neonatal intensive care, and pediatric trauma patients. These facilities may be requested to take care of the most critically injured children throughout LAG.</u></p>	<p><u>Pediatric Trauma Centers Pediatric Medical Centers (PICU, Peds Acute, and NICU)</u></p>	<p><u>Most critically ill and/or injured children</u></p>	<p><u>Expand PICU and peds acute care bed capacity for medical and trauma scenarios</u></p>
<p><u>2 Tier 2 Hospitals are those facilities that are medically equipped to care for children including pediatric intensive care, pediatric acute care, and neonatal intensive care patients. These facilities may be requested to take care of the most critically ill children throughout LAG.</u></p>	<p><u>Pediatric Medical Centers or Full Pediatric Complement (PICU, Peds Acute, and NICU)</u></p>	<p><u>Used primarily for medical surge ; most critically ill children</u></p>	<p><u>Expand peds acute care and PICU bed capacity for medical scenarios</u></p>
<p><u>3 Tier 3 Hospitals are adult trauma</u></p>	<p><u>Adult Trauma Centers No PICU capability but may be able to surgically handle</u></p>	<p><u>Used primarily for critical trauma surge</u></p>	<p><u>Use for a trauma surge event and overflow for</u></p>

<p><u>centers in LAC. These facilities do not have PICU capability but may be able to surgically handle traumatic injuries in children. If a PICU surge is greater than the surge targets for Tier 1 and 2 hospitals, this group of hospitals may be called upon to care for the additional surge of five PICU patients each.</u></p>	<p><u>traumatic injuries in children. If a PICU surge is greater than the surge targets for Tier 1 and 2 hospitals, this group of hospitals may be called upon to care for the additional surge of five PICU patients each.</u></p>		<p><u>intensive care</u></p>
<p><u>4 Tier 4 Hospitals provide inpatient pediatric acute care and all but three are EDAP facilities. <i>Non-EDAP facilities are indicated in italics.</i> Tier 4 hospitals may be requested to accept lower acuity patients compared to Tiers 1, 2, and 3</u></p>	<p><u>Pediatric emergency services with acute pediatric inpatient beds</u> <u>Non-EDAP facilities included</u></p>	<p><u>Lower acuity patients and services, but would be used following tiers 1, 2 and 3</u></p>	<p><u>Expand pediatric acute care beds</u></p>
<p><u>5 Tier 5 Hospital includes hospitals that are EDAP, but do not provide inpatient</u></p>	<p><u>Pediatric emergency services but no acute pediatric inpatient or PICU beds</u> <u>Non-EDAP facilities included</u></p>	<p><u>Ideally for children over 8 years old Respiratory, simple fractures, surgical cases. Possibly use NICU for children ages 1 and younger</u></p>	<p><u>Adult medical/surgical and/or ICU beds carved out in a specific area</u></p>

<p><u>pediatric services. These facilities may be requested to provide inpatient surge capacity for stable patients who are ideally over age eight. <i>The Kaiser Foundation Hospitals (in italics) are non-EDAP facilities but have the capabilities of EDAP facilities.</i></u></p>			
<p><u>6 Tier 6—Hospitals are facilities that are non-EDAP and do not have licensed inpatient pediatric beds. These facilities may be requested to surge for stable patients over eight years of age. <i>Italicized hospitals have NICU capability and may be able to use surge strategies to accommodate patients age one years and under⁴.</i></u></p>	<p><u>Not EDAP and no pediatric inpatient care</u></p> <p><u>NICU capability</u></p>	<p><u>Stable patients older than 8 years old</u></p>	<p><u>Adult medical/surgical and/or ICU beds carved out in a specific area</u></p>
<p><u>7 Tier 7—Hospitals are specialty hospitals or facilities without 9-1-1 receiving emergency departments.</u></p>	<p><u>No emergency services and/or specialty type hospitals</u></p>	<p><u>Use as a specialty resource</u></p>	<p><u>Transfer patients based on specialty</u></p>

These facilities may be used for transfer once a patient is stable based on their capabilities.			
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Appendix CA

Hospital Listing by Pediatric Surge Tier

The following lists outline the surge targets for each hospital within LAC. Surge targets are based on existing pediatric capacity and capability.

REVISED – July 24, 2023 March 27, 2024

Hospital	Capability	Tier	Surge
Cedars-Sinai Medical Center	PMC/PTC	1	20
Children’s Hospital Los Angeles	PMC/PTC	1	20
Dignity Health Northridge Hospital Medical Center	PMC/PTC	1	20
LAC Harbor UCLA Medical Center	PMC/PTC	1	20
Los Angeles General Medical Center	PMC/PTC	1	20
MemorialCare Long Beach/Miller Children’s Hospital	PMC/PTC	1	20
Ronald Reagan UCLA Medical Center	PMC/PTC	1	20
Kaiser Foundation Hospital Los Angeles	PG	2	15
Providence Cedars-Sinai Tarzana Medical Center	EDAP	2	15
Santa Monica UCLA Medical Center	EDAP	2	15
Valley Presbyterian Hospital	PMC	2	15
Antelope Valley Hospital	AT	3	20
Dignity Health California Hospital Medical Center	AT	3	20
Dignity Health-St. Mary Medical Center	AT	3	20
Henry Mayo Newhall Hospital	AT	3	20
Huntington Hospital	AT	3	20
Pomona Valley Hospital Medical Center	AT	2-3	20
Providence Holy Cross Medical Center	AT	3	20
Saint Francis Medical Center	AT	3	20
Adventist Health White Memorial	EDAP	2-4	15
Beverly Hospital	Non-EDAP	4	15

Hospital	Capability	Tier	Surge
Emanate Health Queen of the Valley Hospital	EDAP	4	15
Greater El Monte Community Hospital	PC	4	15
Hollywood Presbyterian Medical Center	PC	4	15
Kaiser Foundation Hospital- Woodland Hills	PC	4 (5) 2	15
LAC Olive View—UCLA Medical Center	EDAP	4	15
Providence Little Company of Mary MC Torrance	EDAP	4	15
Torrance Memorial Medical Center	EDAP	4	15
Adventist Health Glendale	EDAP	5	15
Centinela Hospital Medical Center	EDAP	5	15
Dignity Health Glendale Memorial Hospital	EDAP	5	15
Encino Hospital Medical Center	EDAP	5	15
Kaiser Foundation Hospital- Baldwin Park	PC	5	15
Kaiser Foundation Hospital- Panorama City	PC	5	15
Kaiser Foundation Hospital- South Bay	PC	5	15
Kaiser Foundation Hospital- West Los Angeles	PC	5	15
PIH Health Downey Hospital	EDAP	5	15
PIH Health Whittier Hospital	EDAP	5	15
Providence Little Company of Mary MC San Pedro	EDAP	5	15
Providence Saint Joseph Medical Center	EDAP	5	15
Sherman Oaks Hospital	EDAP	5	15
USC Arcadia Hospital	EDAP	5	15
USC Verdugo Hills	EDAP	5	15
West Hills Hospital and Medical Center	EDAP	5	15
Alhambra Hospital Medical Center	Non-EDAP	6	5
Cedars-Sinai Marina dDel Rey Hospital	Non-EDAP	6	5
Coast Plaza Hospital	Non-EDAP	6	5
College Medical Center	Non-EDAP	6	5
East LA Doctor's Hospital	Non-EDAP	6	5
Emanate Health Foothill Presbyterian Hospital	Non-EDAP	6	5
Emanate Health Intercommunity Hospital	Non-EDAP	6	5
Garfield Medical Center	Non-EDAP	6	5
Lakewood Regional Medical Center	Non-EDAP	6	5
Memorial Hospital of Gardena	Non-EDAP	5-6	-15
Mission Community Hospital	Non-EDAP	6	5
Monterey Park Hospital	Non-EDAP	6	5
Pacifica Hospital of the Valley	Non-EDAP	6	5
Palmdale Regional Medical Center	Non-EDAP	6	5
PIH Health Good Samaritan Hospital	Non-EDAP	6	5
Providence Saint John's Health Center	Non-EDAP	6	5
San Dimas Community Hospital	Non-EDAP	6	5
San Gabriel Valley Medical Center	Non-EDAP	6	5
Southern California Hospital at Culver City	Non-EDAP	6	5
Whittier Hospital Medical Center	Non-EDAP	6	5
Barlow Respiratory Hospital	No ED/Specialty	7	0
City of Hope National Medical Center	No ED/Specialty	7	0
Keck Hospital of USC	No ED/Specialty	7	0
LAC Rancho Los Amigos National Rehabilitation Center	No ED/Specialty	7	0
L. A. Downtown Medical Center	No ED/Specialty	7	0

Hospital	Capability	Tier	Surge
<u>USC Kenneth Norris Jr. Cancer Hospital</u>	<u>No ED/Specialty</u>	<u>7</u>	<u>0</u>
<u>California Rehabilitation Institute</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Gasa Colina Hospital and Centers for Healthcare</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Catalina Island Medical Center</u>	<u>Geographic</u>	<u>UN</u>	<u>0</u>
<u>Community Hospital of Huntington Park</u>	<u>Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Kaiser Foundation Hospital-Downey (REVISIT)</u>	<u>Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Kindred Hospital Baldwin Park</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Kindred Hospital La Mirada</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Kindred Hospital Los Angeles</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Kindred Hospital Paramount</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Kindred Hospital San Gabriel</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Kindred Hospital South Bay</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Los Angeles Community Hospital</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Martin Luther King Jr. Community Hospital</u>	<u>Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Monrovia Memorial Hospital Long Term Facility</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Norwalk Community Hospital</u>	<u>Unsigned Agreement</u>	<u>UN</u>	<u>0</u>
<u>Southern California Hospital at Hollywood</u>	<u>No ED/Unsigned Agreement</u>	<u>UN</u>	<u>0</u>

~~Tier 1 Hospitals (Pediatric Trauma Capable) Total=7 (20)~~

~~Tier 2 Hospitals (Pediatric Medical Capable) Total =4 (15)~~

~~Tier 3 Hospitals (Adult Trauma Centers) Total=8 (20)~~

~~Tier 4 Hospitals (Pediatric Acute Inpatient) Total=9 (15)~~

~~Tier 5 Hospitals (EDAP hospitals or equivalent **NO inpatient pediatric beds**) Total=16 (15)~~

~~Tier 6 Hospitals (Non-EDAP – No Pediatric Services) Total =20 21 (5)~~

~~Tier 7 Hospitals (Non-ED/ Specialty Centers) Total=6~~

~~Unsigned Total= 16~~

REVISED – 2022 November

Hospital	Capability	Tier	Surge
<u>Cedars-Sinai Medical Center</u>	<u>PMC/PTC</u>	<u>4</u>	<u>20</u>
<u>Children's Hospital Los Angeles</u>	<u>PMC/PTC</u>	<u>4</u>	<u>20</u>
<u>Dignity Health-Northridge Hospital Medical Center</u>	<u>PMC/PTC</u>	<u>4</u>	<u>20</u>
<u>LAC Harbor UCLA Medical Center</u>	<u>PMC/PTC</u>	<u>4</u>	<u>20</u>
<u>LAC+USC Medical Center</u>	<u>PMC/PTC</u>	<u>4</u>	<u>20</u>
<u>MemorialCare Long Beach/Miller Children's Hospital</u>	<u>PMC/PTC</u>	<u>4</u>	<u>20</u>
<u>Ronald Reagan UCLA Medical Center</u>	<u>PMC/PTC</u>	<u>4</u>	<u>20</u>

Hospital	Capability	Tier	Surge
Kaiser Foundation Hospital Los Angeles Medical Center	EDAP-C	2	15
Providence Tarzan Cedars-Sinai Medical Center	PMC	2	15
Santa Monica-UCLA Medical Center	EDAP	2	15
Valley Presbyterian Hospital	PMC	2	15
Antelope Valley Hospital	AT	3	20
Dignity Health-California Hospital Medical Center	AT	3	20
Dignity Health-Saint Mary Medical Center	AT	3	20
Henry Mayo Newhall Hospital	AT	3	20
Huntington Memorial	PMCAI	23	20
Pomona Valley Medical Center	AT	3	20
Providence Holy Cross Medical Center	AT	3	20
Saint Francis Medical Center	AT	3	20
Adventist Health-White Memorial	PMCEDAP	24	15
Beverly Hospital	EDAP	4	15
Emanate Health-Queen of the Valley	EDAP	4	15
Greater El Monte Community Hospital	EDAP-C	4	15
Hollywood Presbyterian Medical Center	EDAP-C	4	15
Kaiser Foundation Hospital-Woodland Hills	EDAP-C	4	15
LAC Olive View-UCLA Medical Center	EDAP	4	15
Providence Little Company of Mary-Torrance	EDAP	4	15
Torrance Memorial	EDAP	4	15
Adventist Health-Glendale Medical Center	EDAP	5	15
Gentelna Hospital Medical Center	EDAP	5	15
Dignity Health-Glendale Memorial Hospital	EDAP	5	15
Encino Hospital Medical Center	EDAP	5	15
Kaiser Foundation Hospital-Baldwin Park	EDAP-C	5	15
Kaiser Foundation Hospital-Panorama City	EDAP-C	5	15
Kaiser Foundation Hospital-South Bay	EDAP-C	5	15
Kaiser Foundation Hospital-West Los Angeles	EDAP-C	5	15
PIH Health-Downey	EDAP	5	15
PIH Health-Whittier	EDAP	5	15
Providence Little Company of Mary-San Pedro	EDAP	5	15
Providence Saint Joseph Medical Center	EDAP	5	15
Sherman Oaks Hospital	EDAP	5	15
USC Arcadia Hospital	EDAP	5	15
USC Verdugo Hills	EDAP	5	15
West Hills Medical Center	EDAP	5	15
Alhambra Hospital Medical Center	Non-EDAP	6	5
Cedars-Sinai Marina del Rey	Non-EDAP	6	5
Coast Plaza Doctor's Hospital ⁺	Non-EDAP	6	5
College Medical Center	Non-EDAP	6	5
East LA Doctor's Hospital	Non-EDAP	6	5
Emanate Health-Foothill Presbyterian Hospital	Non-EDAP	6	5
Emanate Health-Intercommunity Hospital	Non-EDAP	6	5
Garfield Medical Center ⁺	Non-EDAP	6	5
Lakewood Regional Medical Center	Non-EDAP	6	5
Memorial Hospital of Gardena	Non-EDAP	56	15
Mission Community Hospital	Non-EDAP	6	5

Hospital	Capability	Tier	Surge
Monterey Park Hospital	Non-EDAP	6	5
Pacifica Hospital of the Valley	Non-EDAP	6	5
Palmdale Regional Medical Center	Non-EDAP	6	5
PIH Health Good Samaritan Hospital ¹	Non-EDAP	6	5
Providence Saint John's Health Center ¹	Non-EDAP	6	5
San Dimas Community Hospital	Non-EDAP	6	5
San Gabriel Valley Medical Center ¹	Non-EDAP	6	5
Southern California Hospital at Culver City	Non-EDAP	6	5
Whittier Hospital Medical Center	Non-EDAP	6	5
Barlow Respiratory Hospital	No ED/Specialty	7	0
City of Hope National Medical Center	No ED/Specialty	7	0
Keck Hospital of USC	No ED/Specialty	7	0
LAC Rancho Los Amigos National Rehabilitation Center	No ED/Specialty	7	0
L.A. Downtown Medical Center	No ED/Specialty	7	0
USC Kenneth Norris Jr. Cancer Hospital	No ED/Specialty	7	0
California Rehabilitation Institute	No ED/Unsigned Agreement	UN	0
Casa Colina Hospital and Centers for Healthcare	No ED/Unsigned Agreement	UN	0
Catalina Island Medical Center	Geographic	UN	0
Community Hospital of Huntington Park	Unsigned Agreement	UN	0
Kaiser Foundation Hospital- Downey	Unsigned Agreement	UN	0
Kindred Hospital Baldwin Park	No ED/Unsigned Agreement	UN	0
Kindred Hospital La Mirada	No ED/Unsigned Agreement	UN	0
Kindred Hospital Los Angeles	No ED/Unsigned Agreement	UN	0
Kindred Hospital Paramount	No ED/Unsigned Agreement	UN	0
Kindred Hospital San Gabriel	No ED/Unsigned Agreement	UN	0
Kindred Hospital South Bay	No ED/Unsigned Agreement	UN	0
Los Angeles Community Hospital	No ED/Unsigned Agreement	UN	0
Martin Luther King Jr.-	Unsigned Agreement	UN	0
Monrovia Memorial Hospital	No ED/Unsigned Agreement	UN	0
Norwalk Community Hospital	Unsigned Agreement	UN	0
Southern California Hospital at Hollywood	No ED/Unsigned Agreement	UN	0

~~Tier 1 Hospitals~~ (Pediatric Trauma Capable) Total=7 (20)

~~Tier 2 Hospitals~~ (Pediatric Medical Capable) Total =4? (15)

~~Tier 3 Hospitals (Adult Trauma Centers) Total=8 (20)~~
~~Tier 4 Hospitals (Pediatric Acute Inpatient) Total=9? (15)~~
~~Tier 5 Hospitals (EDAP hospitals or equivalent **NO inpatient pediatric beds**) Total=16 (15)~~
~~Tier 6 Hospitals (Non-EDAP No Pediatric Services) Total =20 (5)~~
~~Tier 7 Hospitals (Non-ED/ Specialty Centers) Total=6~~
~~Unsigned Total= 16~~

Definitions:

~~**Tier 1** Hospitals are those facilities that currently care for pediatric intensive care, pediatric acute care, neonatal intensive care patients, as well as and pediatric trauma patients. These facilities may be requested to take care of the most critically injured children throughout LAC.~~

~~**Tier 2** Hospitals are those facilities that are medically equipped to care for children including pediatric intensive care, pediatric acute care, and neonatal intensive care patients. These facilities may be requested to take care of the most critically ill children throughout LAC.~~

~~**Tier 3** Hospitals are adult trauma centers in LAC. These facilities do not have PICU capability but may be able to surgically handle traumatic injuries in children. If a PICU surge is greater than the surge targets for Tier 1 and 2 hospitals, this group of hospitals may be called upon to care for the additional surge of five PICU patients each.~~

~~**Tier 4** Hospitals provide inpatient pediatric acute care and all but three are EDAP facilities. *Non-EDAP facilities are indicated in italics.* Tier 4 hospitals may be requested to accept lower acuity patients compared to Tiers 1, 2, and 3.~~

~~**Tier 5** Hospitals includes hospitals that are EDAP, but do not provide inpatient pediatric services. These facilities may be requested to provide inpatient surge capacity for stable patients who are ideally over age eight. *The Kaiser Foundation Hospitals (in italics) are non-EDAP facilities but have the capabilities of EDAP facilities.*~~

~~**Tier 6** Hospitals are facilities that are non-EDAP and do not have licensed inpatient pediatric beds. These facilities may be requested to surge for stable patients over eight years of age. Five of the italicized hospitals have NICU capability and may be able to use surge strategies to accommodate patients age two years and under¹. East LA Doctors Hospital has a seven bed pediatric acute care unit.²~~

~~**Tier 7** Hospitals are specialty hospitals or facilities without 9-1-1 receiving emergency departments. These facilities may be used for transfer once a patient is stable based on their capabilities.~~

~~**Undesignated** These hospitals have not been assigned to a Pediatric Surge Plan tier category either because of geographic location or lack of a signed commitment letter by the CEO.~~

PTC=Pediatric Trauma Center
PMC=Pediatric Medical Center
AT=Adult Trauma

EDAP= Emergency Department Approved for Pediatrics

~~PSR= EDAP-C=EDAP Pediatric Surge Ready Capable but not approved Hospitals with pediatric inpatient services~~

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Appendix B

Tier Capability and Surge Capacity Overview

The below table is a high-level overview of the pediatric surge plan including the tiers, tier criteria, types of patients, and proposed surge approach. **Appendix A** lists the hospitals that comprise each tier.

Tier	Tier Criteria	Types of Patients Recommended for the Tier	Proposed Surge Capacity Strategy
1	Pediatric Trauma Centers Pediatric Medical Centers (PICU, Peds Acute, and NICU)	Most critically ill and/or injured children	Expand PICU and peds acute care bed capacity for medical and trauma scenarios
2	Pediatric Medical Centers or Full Pediatric Complement (PICU, Peds Acute, and NICU)	Used primarily for medical surge	Expand peds acute care and PICU bed capacity for medical scenarios
3	Adult Trauma Centers	Used primarily for critical trauma surge	Use for a trauma surge event and overflow for intensive care
4	Pediatric emergency services with acute pediatric beds	All patients and services, but would be used following tiers 1 and 2	Expand pediatric acute care beds
5	EDAP Pediatric emergency services with no acute pediatric inpatient or PICU care beds	Ideally for children over 8 years old Respiratory, simple fractures, surgical cases. Possibly use NICU for children ages 2 and younger	Adult medical/surgical and/or ICU beds carved out in a specific area
6	Not EDAP and no pediatric inpatient care	Stable patients older than 8 years old	Adult medical/surgical and/or ICU beds carved out in a specific area
7	No emergency services and/or specialty-type hospitals	Use as a specialty resource	Transfer patients based on specialty

Appendix ~~CD~~

Background, Initial Needs Assessment, and Gap Analysis

BACKGROUND

~~As a recipient of Hospital Preparedness Program (HPP) funding, Los Angeles County (LAC) Emergency Medical Services (EMS) Agency has been working on enhancing the surge capacity and capabilities of the healthcare community in order to effectively respond to mass casualty incidents due to terrorism or natural disasters. The Pediatric Surge Program was initiated following the 2009 H1N1 pandemic that disproportionately affected children and stressed hospital systems' capacity for pediatric intensive care unit (PICU) beds and equipment, such as pediatric ventilators.~~

~~This program includes a countywide plan on how each hospital within LAC would contribute to caring for pediatric patients in the event of a surge that largely impacts children. This plan is aligned with and supports LAC's compliance with the HPP Capabilities Capability 1: Healthcare System Preparedness; Function 7, coordinate with planning for at-risk individuals and those with special medical needs, and Capability 10: Medical Surge. Children are a designated vulnerable population requiring special planning and response. This plan provides details on how each hospital within LAC will support a pediatric surge of patients including surge targets and patient type. This plan also includes parameters for transporting children from prehospital field operations to healthcare facilities and transferring of patients amongst hospitals.~~

~~**Program Goal:** To enhance LAC's pediatric surge capacity to meet the medical needs of children during a disaster. The LAC surge target is to enhance pediatric capacity by 100%.~~

~~CURRENT STATUS (As of original publication of this plan, May 2013)~~

~~**Current Status of Pediatric Care**~~

~~The 4,084 square miles of LAC is home to 2.8 million children ages 18 and under. This equates to 2020% of the total LAC population (U.S. Census 20102022). LAC Department of Public Health uses Service Planning Areas (SPAs) in the county to plan public health and clinical services for the residents of these areas. LAC is divided into eight distinct geographic areas: Antelope Valley, East, Metro, San Fernando, San Gabriel, South, South Bay, and West. These areas are shown in Figure 1.~~

Figure 1 - Population density map

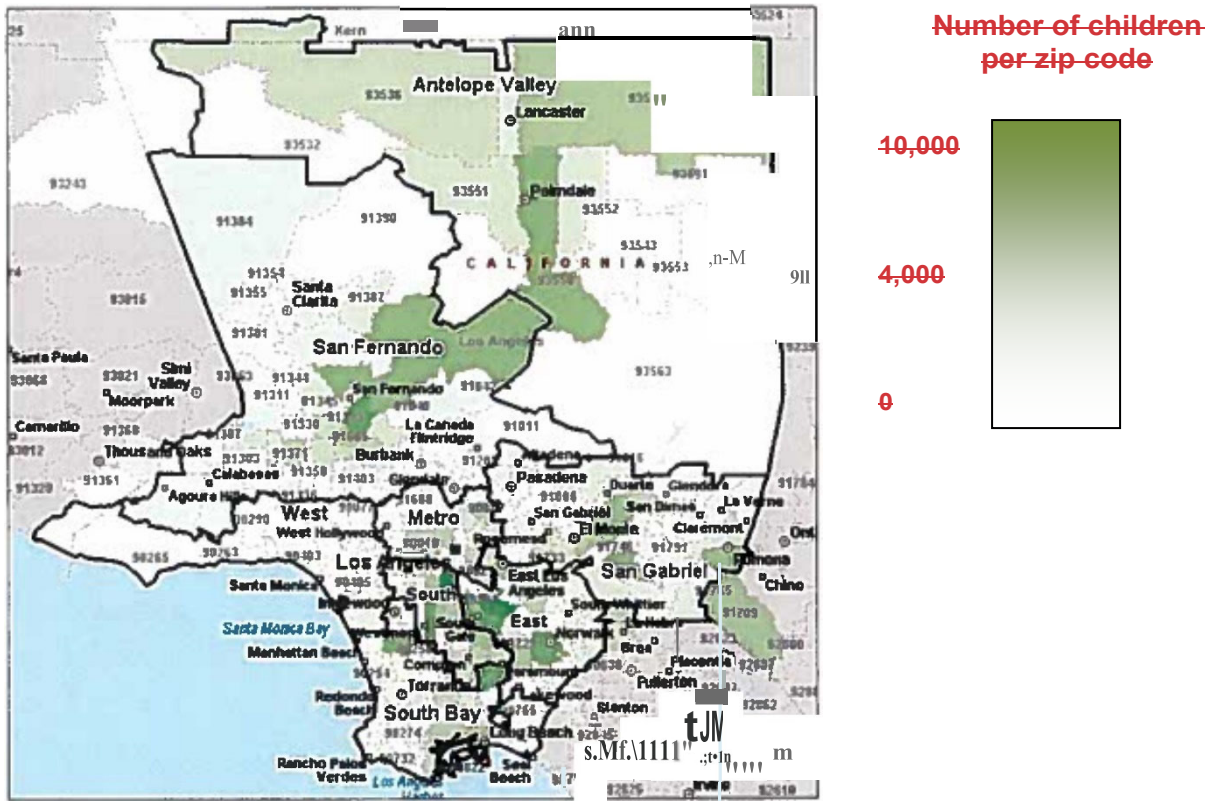


Figure 2—Population and beds by Service Planning Area

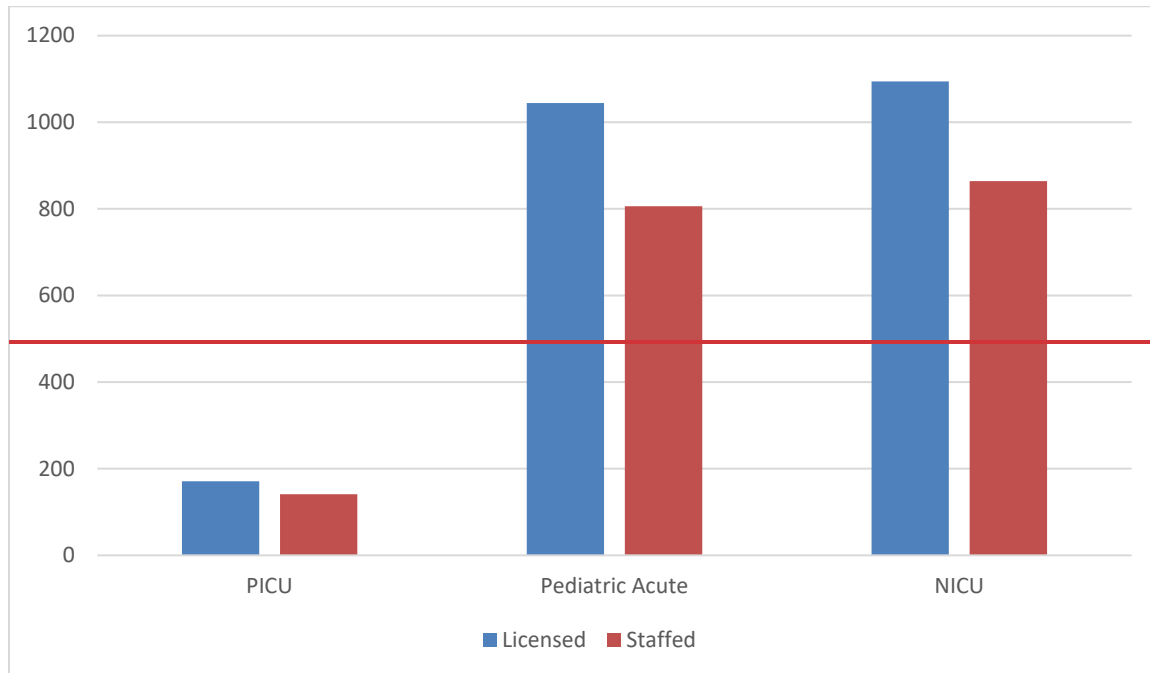
Service-Planning-Area-(SPA)	Pediatric-Population	Licensed PICU-Beds	Total Capacity-During-Pediatric Surge	Licensed Beds-per-100-Children
Antelope-Valley	113,511	0	22	0.19
East	379,976	0	105	0.28
Metro	283,977	97	385	1.36
San-Fernando	532,864	18	90	0.17
San-Gabriel	459,786	8	11	0.24
South	340,370	0	14	0.04
South-Bay	388,105	30	199	0.51
West	107,981	24	57	0.53

Sources-Figures 1 and 2: Population—Nielsen Claritas 2009, Ages 0-17. Bed Data—Combination of OSHPD YE 2010 updated with Pediatric Surge Plan Survey data.

Pediatric Bed Capacity

Figure 3 shows the California Office of Statewide Health Planning and Development (OSHPD) data year ending June 2010 which was used as a method for calculating the surge targets for this plan. The number of staffed beds was used as a baseline to calculate the surge target of 100% bed capacity.

Figure 3— Pediatric bed capacity



Distribution of Pediatric Services in Los Angeles County Hospitals

Figure 4— Hospitals with pediatric units

	NICU-Only	Pediatric Acute-Unit-Only	NICU-and-Pediatric-Acute-Unit	PICU, NICU-and-Pediatric-Acute-Unit	No-Pediatric-Inpatient-Services
Number of Hospitals	15	11	16	13	32

Sources Figure 3: OSHPD Year Ending June 2010

Figure 4: OSHPD Year Ending June 2010 and Pediatric Surge Plan Survey and Focus Group data

SIMULATED BED NEEDS

Based on the LAC Emergency Medical Services Agency Gap Analysis project, it is estimated that the following pediatric beds will be needed for each of the following scenarios:

- ~~Pandemic Flu—97,470 pediatric medical/surgical (med/surg) beds and 28,136 PICU beds. This scenario is based on no mitigation efforts, e.g., no vaccinations in the population. Since vaccinations are part of the current healthcare system, it is anticipated that fewer beds will be needed than the above estimates due to the mitigation efforts.~~
- ~~Improvised Explosive Device (IED)—195 pediatric med/surg beds and 52 PICU beds.~~
- ~~Major Earthquake—5,047 total patients with a maximum need of 2,205 ICU beds. A proportional allocation translates to 1,463 pediatric med/surge beds and 639 PICU beds. (Total patients in scenario X 29%, i.e. percent of child population).~~

~~This plan will meet the simulated number of casualties for the IED scenario. LAC's response agencies will need to implement mitigation activities (i.e., vaccination campaign, infection control programs and messaging, and medical countermeasures) for the pandemic flu scenario to reduce the impact of the outbreak and allow the healthcare system to respond to the estimated surge of casualties. This plan will meet the simulated number of critical care patients if adult ICU hospital beds are used in addition to the PICU beds.~~

PEDIATRIC SURGE GAPS AND OPPORTUNITIES

Pediatric Surge Gaps

~~The following gaps have been identified in pediatric surge capacity and capability as a result of the countywide survey and data analysis, which was conducted between April 7 and May 16, 2011 with a 94% (78/83 HPP participating hospitals) response rate.~~

- ~~**Limited Pediatric Bed Capacity on a Daily Basis:** Pediatric bed capacity throughout LAG on any given day is limited. Per the OSHPD data, there are 13 hospitals that provide 13 ? hospitals provide pediatric intensive care services with a total of 141 staffed beds as of June 2010. Forty-seven percent (40/87) of hospitals in LAC provide some type of inpatient pediatric services (OSHPD).~~

~~Eight (8) hospitals are designated as Pediatric Medical Centers (PMC). According to the EMS Agency, Reference 318, PMC Standard, the PMC provides an emergency department capable of managing complex pediatric emergencies, and a Pediatric Intensive Care Unit (PICU), with experience in pediatric critical care.~~

1. ~~Thirty seven (37) Forty one hospitals are designated as Emergency Departments Approved for Pediatrics (EDAP) (LAC EMS Agency 9/2012). According to the EMS Agency Reference 316, EDAP Standards definition, an EDAP facility is "A licensed basic or comprehensive emergency department that is designated approved by the Los Angeles County of Los Angeles Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These emergency departments provide care to pediatric patients by meeting~~

~~specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures."~~

2. ~~**Geographic Variability:** Based on OSHPD 2010 data, the majority (31%) of pediatric beds are located within the Metro SPA, followed by the South Bay SPA (20%). Despite the continued increase in the number of children in the eastern and northern areas of the County such as Santa Clarita and Antelope Valley, pediatric medical and surgical care remains centralized in the Metro SPA area. The Antelope Valley SPA is served by two hospitals, one of which provides pediatric acute hospital services (Antelope Valley Hospital).~~
3. ~~**Limited PICU Capacity:** There are no PICU beds available in the Antelope Valley, East, or South SPA. For facilities with PICU beds, the average daily census ranged from one to twenty two, with an average of 7.31. Three facilities with PICUs reported an average daily census greater than eight.~~
4. ~~**Limited Pediatric Specialty Physician Resources:** Half of the facilities reporting the availability of pediatric general surgeons have contracts with those physicians. The contracts are not necessarily exclusive; therefore, it is possible the data overestimates the availability of pediatric surgeons. Twenty facilities reported having pediatric anesthesiologists. Of those reporting, nine indicated they were hospital-based, another nine indicated they were contract physicians, while two responses were left blank. Nine out of 15 (60%) facilities with pediatric emergency medicine have dedicated physicians. This will require emergency medicine physicians and emergency departments, regardless of EDAP status, to be prepared at a basic level to handle pediatric emergencies.~~
5. ~~**Varying Availability of Pediatric Trained Staff:** Staffing resources vary by facility. Of the 21,175 nurses reported in the survey, 6,557 (31%) are reported as certified in Pediatric Advanced Life Support (PALS). Two percent of reported nurses had taken the Emergency Nursing Pediatric Course. Of the Respiratory Therapists reported, over half are PALS certified (55.6%).~~
6. ~~**Less Availability of Pediatric Critical Care Supplies:** Eighty-eight percent of facilities reported having code blue carts with pediatric drugs and intubation supplies. Sixty-seven percent have routine EDAP or pediatric equipment supply carts. However, 68% percent of facilities reported having pediatric critical care supplies and equipment.~~
7. ~~**Limited Ability to Accept and Receive Children:** Forty-one percent of facilities reported that they had a physician available 24/7 that could accept pediatric patients to their hospital for inpatient admission. Fifty-three percent of the facilities are EDAP.~~

Surge Capacity Opportunity

Based on the survey findings, there is an opportunity for hospitals to use additional space to increase surge capacity within their facilities. Two opportunities throughout the Los Angeles county County include the Post Anesthetic Care Unit (PACU) and outpatient clinic space. Below are some significant statistics of these areas:

— PACU beds

- 53% of facilities currently care for children in their PACU
- 444 PACU beds exist
- Average of 9 nurses in each PACU

— Outpatient Clinic

- 25% of hospital facilities operate pediatric outpatient clinics
- Median volume = 80 visits per day
- 482 patient rooms
- 144 nurses and 188 physicians¹

1. Physician and nursing data is likely an underestimate. Data was incomplete. Four hospitals indicating they had capacity did not report nursing and physician numbers. An additional two locations did not report the number of nurses.

Countywide Pediatric Surge Targets

Surge targets are calculated based on pediatric capacity and capability. The surge goal is based on 100% of staffed bed capacity reported by hospitals to OSHPD for the year ending June 2010.

Figure 5—Surge target goals

Bed-Type	Current Staffed Beds	Surge Goal—100% of surge capacity	Total Capacity During Pediatric Surge
PICU	141	141	282
Pediatric Acute Beds	806	806	1612

Source: OSHPD Year-Ending June 2010

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~~Appendix D~~

~~Training and Plan Distribution~~

~~Training~~

~~Pediatric Surge Training Components~~

~~A total of six initial 3-hour training sessions were held throughout LAC between December 2012 and April 2013. A total of 326 individuals received the training. A recorded DVD with both parts of the training is available at each hospital for just-in-time training.~~

~~Part One~~

~~Target Audience:~~

- ~~• Emergency preparedness planners~~
- ~~• Emergency department and inpatient clinical staff (physicians and nurses)~~
- ~~• Public and private EMS provider agencies~~
- ~~• Base hospital personnel~~

~~Content:~~

- ~~• Pediatric surge plan overview~~
- ~~• Triage including JumpStart and Pediatric Assessment Triangle~~
- ~~• Age-specific care~~
- ~~• Disaster management safe area, security needs~~

~~Part Two~~

~~Target Audience:~~

- ~~• Emergency preparedness planners~~
- ~~• Emergency department and inpatient clinical staff (physicians and nurses)~~

~~Content:~~

- ~~• How to use a standardized length-based resuscitation tape, to estimate pediatric weights in kilograms (BROSELOW™)~~
- ~~• Assessment – primary and secondary~~
- ~~• Pediatric vulnerabilities~~
- ~~• Diagnosis and treatment of shock~~
- ~~• Identification and management of dehydration~~
- ~~• Identification and management for respiratory distress (subtle nuances of pediatrics)~~
- ~~• Differences between respiratory distress versus respiratory failure~~
- ~~• Medication administration~~
- ~~• Nutrition~~
- ~~• Children with special needs~~

• Mental health strategies for children

Plan Distribution

Pediatric Surge Plan Distribution

Approximately 160 physical binders containing the LAC Pediatric Surge Plan were distributed to LA County participating hospitals in 2014. The Pediatric Surge Plan is also available on the LAC EMS Agency website (available under Disaster Medical Services—Resource Documents).

Recipients:

- LAC HPP Hospital Emergency preparedness planners

Binder Contents:

- Pediatric Surge Plan and Appendices (approved May 2013)
 - Pediatric Surge Quick Reference Guide quad-fold (also available on the LAC EMS website)
 - A DVD with both parts of the training (see 'Training' above) for just-in-time training.
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Appendix E

Exercise Overview and Results

Exercise Overview

The 2015 LA County EMS Agency Pediatric Surge Exercise Series was sponsored by the Los Angeles County Emergency Medical Services Agency (LAC EMS Agency) and Children's Hospital Los Angeles (CHLA) in collaboration with the response partners representing local Emergency Medical Services (EMS), local health departments, public safety and health care facilities. The Exercise Plan was produced with input, advice and assistance from the LAC EMS Agency Pediatric Surge Exercise Design Workgroup, which followed guidance set forth by the U.S. Department of Homeland Security Exercise and Evaluation Program. The exercise tested participants' emergency response plans, policies and procedures as they pertain to a pediatric surge.

Exercise Name	2015 Los Angeles County Pediatric Surge Exercise Series
Exercise Dates	Tabletop Exercise: April 20, 2015, 12:30-3:00 p.m. Functional Exercise: June 11, 2015, 8:00-12:00 p.m.
Scope	This exercise was a functional exercise, planned for June 11, 2015 from 0800-1200 (4 hours) at various healthcare facilities throughout Los Angeles County. This functional exercise was preceded by a Tabletop Exercise on April 20, 2015. The focus was on exercising the LAC EMS Agency Pediatric Surge Plan.
Mission Area(s)	Response
Core Capabilities	1. Emergency Operations Center Management 2. Communications 3. Emergency Triage and Prehospital Treatment 4. Medical Surge
Objectives	1. Activate and use Incident Command System (ICS) principles (ICS, Hospital Incident Command System, and Standardized Emergency Management System) across all levels of the medical health system. 2. Evaluate the ability to use existing systems to communicate the medical and health needs of children. 3. Assess prehospital coordination with the Medical Alert Center.(MAC) 4. Evaluate the ability of medical and health partners to activate pediatric surge plans within established protocols and to accept surge patients according to the plan. 5. Assess MAC's capability to coordinate the destination of pediatric patients during a surge to various hospitals (from field and transfers).

Threat or Hazard	This scenario was based on a wind event causing disproportionate injury to children resulting from tent collapses and trampling.
Scenario	On June 11, 2015, the inaugural "School Learning Event" took place at four locations around LA County. The event brought together school classes for a day of interactive learning. The event locations were Santa Clarita Valley, Pomona Valley, Long Beach, and LA Live. Concurrent gusts of wind caused tent collapses and trampling injuries. Estimates of injured were in the hundreds over the four locations, with most victims between ages 5-12 years old.
Sponsor	This exercise was sponsored by the Los Angeles County Emergency Services Agency, with support from Children's Hospital Los Angeles. The exercise was funded by grant number: 5U90TP000516-02
Participating Organizations	This exercise was designed to include HPP hospitals within Los Angeles County, the LAC EMS Agency MAG, and representatives from LA County, LA City, and Long Beach Fire Departments.

The Pediatric Surge Plan Exercise Series, in compliance with the U.S. Department of Homeland Security Exercise and Evaluation Program, consisted of the following training and exercise dates:

Date	Event	Time	Location
March 24, 2015	Pre-conference	0900-1200	Presbyterian Intercommunity Hospital
April 20, 2015	Controller and Evaluator Training	0930-1200	Santa Fe Springs Town Center
April 20, 2015	Tabletop Exercise	1230-1500	Santa Fe Springs Town Center
June 2, 2015	Evaluator Training-Refresher	1000-1100	Webinar
June 11, 2015	Functional Exercise	0800-1200	LAC EMS Agency and all participating LAC HPP hospitals
June 16, 2015	Exercise Evaluation-Conference	0900-1200	Santa Fe Springs Town Center

Exercise Results

Tabletop Exercise

- ~~Representatives from 60 individual hospitals participated in the tabletop exercise.~~
- ~~Representatives from the LAC EMS Agency, the LAC EMS Agency Medical Alert Center, Los Angeles Fire Department, and Long Beach Fire Department were also in attendance.~~

Functional Exercise

- ~~38 individual hospitals participated in the exercise, either as a full functional exercise or as a tabletop exercise.~~
- ~~Representatives from the LAC EMS Agency, the LAC EMS Agency Medical Alert Center, the Los Angeles Fire Department, and Long Beach Fire Department also participated.~~
- ~~The LAC EMS Agency activated their Department Operations Center (DOC) for the management of the four simulated incident sites for the exercise.~~
- ~~A SimCell was used to simulate communication and coordination with local, county, and other partners not participating in the exercise.~~

Major Strengths

- ~~The hospitals were able to meet the surge expectations for their tier, as described in the LAC Pediatric Surge Plan.~~
- ~~Participating hospitals were able to work through and resolve pediatric-specific concerns.~~
- ~~The Medical Alert Center was able to find destinations for all patients, from the field and accommodated secondary transfers.~~

Primary Areas for Improvement

- ~~Tier 1 facilities need to be differentiated based on their medical and trauma capabilities in the LAC Pediatric Surge Plan. Since resources vary between trauma and non-trauma centers, a distinction between the two is necessary in the plan. This is particularly critical if a pediatric surge is due to a trauma event, as was simulated in this exercise. Through the exercise process, there was considerable discussion regarding prehospital personnel daily protocols for patient destination.~~
- ~~Additional training on ReddiNet® is needed for hospital staff. Many facilities indicated that inputting and tracking patients from a surge event was time-consuming and could be improved.~~
- ~~There is a need for advanced and just-in-time training resources regarding pediatric-specific concerns, particularly for lower-tiered hospitals.~~
- ~~Facilities would benefit from leveraging regional resources, beyond county borders, when planning for a pediatric surge event.~~

Future Opportunities for Consideration

~~While reunification processes and regional resources were not tested during the exercise, both were discussed in depth by participating agencies. Reunification and Family Information Center plans were described as areas that can be improved for all those who participated. Many site-specific policies and procedures regarding reunification need further development.~~

~~This exercise also prompted discussions regarding coordination of multi-site MCIs and regional pediatric surge response. Some considerations for improving this include:~~

- ~~• Knowledge and use of the Fire Operational Area Coordinator (FOAC) and Medical and Health Operational Area Coordinator (MHOAC) for additional resources~~
- ~~• Development of regional or statewide coordinating plans for pediatric surge~~

Exercise Summary

~~The functional exercise on June 11th, 2015 was successful in testing the LAC Pediatric Surge Plan. The expectations detailed in the plan, regarding the pediatric surge capacity of LAC and of individual hospitals, were validated in the exercise as hospitals were able to meet surge targets based on their individual hospital tier. Areas for plan improvement were identified, with the focus of making the plan more operational. The primary edit to the LAC Pediatric Surge plan will be the categorization of trauma center and non-trauma medical centers into two distinct tiers.~~

~~During the exercise, two secondary transfers were transferred out of the county by the Medical Alert Center (MAC). As the MAC and many LAC hospitals regularly work with hospitals outside of LAC geographic lines, regional planning and training are needed in preparing for a pediatric surge event. Additionally, many concerns regarding the reunification of unaccompanied minors and guardians were discussed throughout the planning and exercise process. Since the Pediatric Surge Plan focuses on the distribution and accommodation of pediatric patients and our exercise did not specifically test reunification processes or communication efforts, future exercises are warranted to test such capabilities. It is also recommended that pediatric victims be incorporated into future exercises to keep up pediatric training and to facilitate continued discussions about the triage, treatment, and management of pediatric victims in a disaster event.~~

The LAC Pediatric Surge Plan was edited based on the findings of this exercise series.

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Appendix F

History and Summary of Revisions

History

The initial needs assessment and gap analysis for the Los Angeles County Pediatric Surge Plan were conducted in 2011. The LAC Pediatric Surge Plan was initially approved in May 2013.

Summary of Revisions

September 2015

The following edits were made to the original LAC Pediatric Surge Plan after the completion of the Pediatric Surge Tabletop and Functional Exercises held on April 20, 2015 and June 11, 2015 respectively.

- 1) The original Tier 1 hospitals were separated into trauma centers and non-trauma medical centers and are now classified as Tier 1 and Tier 2, respectively. These classifications are assigned based on the resources available at the hospital. This alteration addresses issues of Tier 1 non-trauma hospitals receiving pediatric patients who need specialized trauma care, which became apparent during pre-exercise planning and the exercise in June 2015. The remaining tiers are reorganized to reflect the addition of the non-trauma medical center category, such that the existing Tier 2 becomes Tier 3, and so on.
- 2) The overall surge capacity has changed by five (5) pediatric intensive care unit (PICU) beds and 50 pediatric acute care beds due to the following:
 - a. The loss of EDAP status for Southern California Hospital Culver City and San Gabriel Valley Medical Center. Both of these hospitals are now classified as Tier 5 and each have a pediatric acute surge capacity of five beds. This is a reduction from the Tier 4 capacity of 15 Acute beds per hospital; the total loss of capacity is 20 pediatric acute care surge beds.
- 3) The Pediatric Surge Plan was reorganized so that the plan is more concise.
 - a. The Pediatric Surge Plan was revised into a shorter document for ease of use and revision.
 - b. Background, Current Status, Initial Needs Assessment, and Gap Analysis were moved to the Appendices.
 - c. The training section was moved to the Appendices.
- 4) Appendices B, D, E, H, I, and J were added.

Ongoing

Individual hospital designations and status changes will be updated annually in **Appendix A**.

~~Appendix GE~~

~~Strategies for Enhancing Surge Capacity Excerpt from the Los Angeles County Mass Medical Care Model~~

~~Health care surge capacities.~~

~~Key Response and Surge Strategies~~

~~**Primary goal:** To maintain operations and increase capacity in order to preserve the life and safety of patients and ensure appropriate healthcare delivery to the community.~~

~~**Indicators:** All of the following indicators would need to be met prior to surge strategy implementation:~~

- ~~• All staffed beds are filled appropriately~~
- ~~• Discharges have been expedited~~
- ~~• Elective and outpatient surgeries have been canceled~~
- ~~• Patients have been appropriately downgraded~~

CHECKLIST OF SURGE STRATEGY IMPLEMENTATION

SPACE – Surge Strategies for Hospitals

Objective: Increase the ability to maintain operations and/or take on additional patients by repurposing the use of space

Strategy/Implementation Steps	Regulatory Considerations
<ul style="list-style-type: none"> • Utilize licensed space for other types of patients • Use outpatient beds for inpatient care • Use internal skilled beds as acute patient areas • Convert adult space to pediatric space • Convert pediatric space to adult space 	<ul style="list-style-type: none"> • 22 CCR 70811(c): Patient rooms which are approved for ambulatory patients only shall not accommodate non-ambulatory patients • 22 CCR 70805: Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of CDPH • 22 CCR 70809(a): No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of justified emergency when temporary permission may be granted by the CDPH Director or designee
<ul style="list-style-type: none"> • Increase capacity in patient rooms or hallways in patient care areas <ul style="list-style-type: none"> • 2 patients in a single room 	<ul style="list-style-type: none"> • 22 CCR 70811(a): Patients shall be accommodated in rooms with a minimum floor area (as detailed in 22 CCR 70811 (a) (1) and (a) (2))
<ul style="list-style-type: none"> • 3 patients in a double room 	<ul style="list-style-type: none"> • 22 CCR 70805: Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of CDPH • 22 CCR 70809(a): No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of justified emergency when temporary permission may be granted by the CDPH Director or his designee

~~SPACE – Surge Strategies for Hospitals~~

~~Objective: Increase the ability to maintain operations and/or take on additional patients by repurposing the use of space~~

Strategy/Implementation Steps	Regulatory Considerations
<ul style="list-style-type: none">• Open hospital floors that are vacant	<ul style="list-style-type: none">• 22 CCR 70805: Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of CDPH• 22 CCR 70809(c): Patients shall not be housed in areas which have not been approved by CDPH for patient housing and which have not been granted a fire clearance by the State Fire Marshall
<ul style="list-style-type: none">• Use areas of the hospital for inpatients<ul style="list-style-type: none">• GI Lab• Recovery Room• Outpatient Surgery• Physical Therapy• Other	<ul style="list-style-type: none">• 22 CCR 70805: Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of CDPH• 22 CCR 70809(c): Patients shall not be housed in areas which have not been approved by CDPH for patient housing and which have not been granted a fire clearance by the State Fire Marshall
<ul style="list-style-type: none">• Use non-traditional areas of the hospital for inpatients<ul style="list-style-type: none">• Cafeterias• Conference Rooms• Parking Structures• Other	<ul style="list-style-type: none">• 22 CCR 70805: Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of CDPH• 22 CCR 70809(c): Patients shall not be housed in areas which have not been approved by CDPH for patient housing and which have not been granted a fire clearance by the State Fire Marshall

SPACE – Surge Strategies for Hospitals

Objective: Increase the ability to maintain operations and/or take on additional patients by repurposing the use of space

Strategy/Implementation Steps	Regulatory Considerations
<ul style="list-style-type: none">• Shut off floor ventilation system to make a cohort of infected patients	<ul style="list-style-type: none">■ 22 CCR 70823: A private room shall be available for any patient in need of physical separation as defined by the infection control committee■ 22 CCR 70855: Heating, air conditioning and ventilation systems shall be maintained in operating condition to provide a comfortable temperature
<ul style="list-style-type: none">• Use tents to create additional patient care areas	<ul style="list-style-type: none">■ 22 CCR 70809(c): Patients shall not be housed in areas which have not been approved by CDPH for patient housing and which have not been granted a fire clearance by the State Fire Marshall

~~STAFF – Surge Strategies for Hospitals~~

~~Objective: Increase the ability to maintain staffing levels and/or expand the workforce~~

Strategy/Implementation Steps	Regulatory Considerations
• Cross train clinical staff	• Age limits to MD Malpractice Coverage
• Contact Nurse staffing agencies (registry) to assist with supplemental staffing needs	
• Use non-conventional staff or expand scope of practice <ul style="list-style-type: none"> • Student nurses • Medical students • Military licensed staff 	• Regulations to expand clinical professionals' scope of practice may require a CDPH waiver and Governor's order. Need clarification from professional boards. <ul style="list-style-type: none"> • 22 CCR 70217: Nurse ratios
• Use of non-conventional staff <ul style="list-style-type: none"> • Volunteers • Paramedics • Dentists • Veterinarians • Retired health professionals with an active license 	• Professionals with inactive licenses will need to go through the process to reactivate it. <ul style="list-style-type: none"> • Liability/licensing regulations • State laws regarding malpractice coverage for volunteers
• Utilize adult skilled RNs to supervise pediatric RNs to treat a surge of adult patients and vice versa	• Liability regulations and insurance limitations
• Utilize families to render care under direction of a healthcare provider	• Title 22 – Certified nursing assistant to render care
• Implement and/or develop just-in-time training for clinical staff normally assigned to non-direct patient care positions	
• Plan for dependent care for staff	
• Provide vaccination and prophylaxis to healthcare staff and their family member, as appropriate	

~~STAFF – Surge Strategies for Hospitals~~

~~Objective: Increase the ability to maintain staffing levels and/or expand the workforce~~

Strategy/Implementation Steps	Regulatory Considerations
• Implement and/or develop return-to-work policies for employees that have recovered from the communicable illness and have immunity	
• Develop procedure to accept and assign volunteers	• Need to review CMS to identify actual standard of primary source verification. Go directly to CMS for clarification
• Request additional staffing resources through the Standardized Emergency Management System (SEMS) structure	
• Request relaxation of nurse/patient ratios to allow occupancy of all licensed beds	• 22 CCR 70217: Nurse ratios • Union regulations • AB 294: California RN Staffing Ratio Law, requires Governor's standby order for statutory suspension

~~STUFF – Surge Strategies for Hospitals~~

~~Objective: Ensure adequate supplies and equipment~~

~~Strategy/Implementation Steps~~

- ~~■ Conserve resources~~
- ~~■ Prioritize care functions to maximize the use of resources (e.g., limit/reduce the frequency of patient baths, etc.)~~
- ~~■ Notify vendors regarding anticipated needs and determine availability~~
- ~~■ Work with alternate vendors to develop agreements regarding acquiring supplies
 - ~~■ Sporting goods stores~~
 - ~~■ Grocery stores~~
 - ~~■ Disaster vendors~~
 - ~~■ Other~~~~
- ~~■ Identify streamlined processes for use of PPE, including guidelines for reuse and fit testing~~
- ~~■ Request resources from LA County EMS Agency to be deployed to Disaster Resource Centers (DRC)s as a distribution point for umbrella facilities as appropriate~~
- ~~— Find/procure alternate ventilator types/sources (e.g., ventilators from local animal hospitals)~~
- ~~— Wrap-em~~
- ~~■ Pediatric Ruddiness~~

~~Appendix F to be added~~

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~~Appendix H F~~

~~Suggested Supplies~~

~~HPP Pediatric Surge Program~~

~~Recommended supplies for each tier Updated May 2013~~

~~*Recommended During the initial plan development and training each hospital within their tier received the following supplies.*~~

~~**Tiers 1, and 2, and 4:** Since these hospitals routinely care for children, Broselow™ kit "bags" will be centrally located and stored at the LAC EMS Agency. A total of 10 bags of Broselow™ kit supplies will be purchased. These supplies could be used by any HPP hospital in the case of a large surge of children and would be requested through the MAC.~~

~~**Tier 3:** Hospitals that are adult trauma hospitals~~

- ~~• 1 Broselow™ cart (pre-assembled) with supplies stocked~~
- ~~• 2 Broselow™ kit "bags"~~

~~**Tier 4:**~~

- ~~• 2 Broselow™ Cart (pre-assembled) with supplies stocked~~
- ~~• 2 Broselow™ Kits (bags)~~
- ~~• _____~~
- ~~• _____~~

~~**Tier 5:** Hospitals that are EDAP, but do not provide inpatient pediatric services~~

- ~~• 1 Broselow™ Cart (pre-assembled) with supplies stocked~~
- ~~• 2 Broselow™ Kits (bags)~~
- ~~• 3 Rigid C Spine collars~~

~~**Tier 6:** Hospitals that are not EDAP and do not have licensed pediatric inpatient beds~~

- ~~• 1 Broselow™ Cart (pre-assembled) with supplies stocked~~
- ~~• 3 Rigid C Spine collars~~

~~**Tier 7:** Specialty hospitals or facilities without 9-1-1 receiving emergency departments~~

- ~~• If these hospitals were "activated" during a pediatric surge to care for children, the LAC EMS Agency DRC cache would be used to provide supplies~~

~~All HPP participating hospitals in LAC were solicited to submit a request to purchase additional pediatric equipment and/or supplies based on self-identification of the need to meet the expectation of this plan.~~

Appendix I

Translating Triage to Tiers: Tool for the LAC EMS Agency Medical Alert Center

Translating Disaster Triage to Tier

Disaster Triage Categories to Tiers (Trauma Event)

The following table is a visual representation of the suggested triage categories to be distributed to each tier in the event of a Pediatric TRAUMA surge event that has a disproportionate number of pediatric victims. **Use of the LA County Trauma system would be used first**

		Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6	Tier 7
Triage-Category	Age							
Immediate	<8-yrs	X						
Immediate	>8-yrs	X		X				
Delayed	<8-yrs	X	X		X	X		
Delayed	>8-yrs			X	X	X	X	Transfer patients
Minor	All				X	X	X	

Legend

Facilities have resources to handle and should be PRIORITIZED to receive these types of patients.
Facilities have resources to handle these types of patients but should be utilized for their priority-patients first.
Facilities are accustomed to handling patients other than this type.

This figure was created as a guide based on feedback during the exercise. Triage categories are used on a routine basis for prehospital providers, whereas the use of a tiered system for the pediatric surge is not. The figure is intended to support the understanding of how the pediatric surge tiers correspond to triage categories.

Distribution of Patients to Tiers (Medical Event)

The following table is a visual representation of the suggested age categories to be distributed to each tier in the event of a MEDICAL surge event that has a disproportionate number of pediatric victims.

	Tier-1	Tier-2	Tier-3	Tier-4	Tier-5	Tier-6	Tier-7
Age							
>8-yrs	X	X		X			
>8-yrs	X	X	X	X	X	X	Transfer patients



Legend

- Facilities have resources to handle and should be **PRIORITIZED** to receive these types of patients.
- Facilities have resources to handle these types of patients but should be utilized for their priority patients first.
- Facilities are accustomed to handling patients other than this type.

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Appendix JG

Children with Access and Functional Needs

INTRODUCTION

Children, especially children with access and functional needs, face barriers in disaster preparedness and response. Based on interviews conducted with hospitals within the Hospital Preparedness Program, parents, and caregivers, the majority of stated that children with access and functional needs in LAC are often cared for at specialty centers such as Children's Hospital Los Angeles and MemorialCare Long Beach Miller's Children Hospital. In an event where the Los Angeles County EMS Agency Pediatric Surge Plan is activated, consideration for these children will need to be taken into account.

Ideally, pediatric patients with access and functional needs should be cared for at Tier 1 facilities (See **Appendix A C** for tier designations). Disasters, however, may cause these children to be diverted to adult hospitals. In the event of a county-wide disaster, all facilities must be prepared to receive pediatric patients with access and functional needs. Facilities need to be prepared not only for a surge of victims, but also need to anticipate an influx of patients seeking shelter. Children with access and functional needs will most likely be accompanied by a parent or caregiver. They may also be accompanied by other family members including siblings who are also children.

The following pages include planning and response considerations for caring for children with access and functional needs during an emergency or disaster. These have been compiled from multiple sources, which are listed starting on **page 48**.

CONSIDERATIONS

Identifying the population

Not all children with access and functional needs show discernible signs of their condition(s). To ensure that all children with access and functional needs are recognized and receive appropriate care, document baseline developmental and functional status in the medical record and use an identifier to convey the patient's need to staff.

Communication

Effective communication is essential during emergencies and disasters. Communication plans need to recognize that traditional methods for the general population may not yield the same result when targeted at children with access and functional needs. To ensure that they receive and understand the information, different techniques may be tailored for children with sensory, mental, cognitive and developmental, and speech or language needs. Examples of alternative methods of communication can be found on **page 48**.

Evacuation

Many children with access and functional needs rely on medical devices and mobility aids. Evacuation and transportation measures will need to account for the movement of the children as well as their equipment. Accessible routes and additional staffing need to be identified in the planning stages to assist with evacuation and transportation.

| _____

Triggers and Cues

Children with access and functional needs, especially those with sensory, mental, and cognitive or developmental conditions, are susceptible to certain behavior triggers and cues. Triggers threaten children's sense of security and safety thus causing them to react negatively and become uncooperative. Cues exhibited by children with access and functional needs can signal when a child has been affected by a trigger. Ways to limit the exposure of children to triggers include placing them in areas where it is quiet and private, offering them comfort items (e.g., stuffed animals), or having activities and games to distract them from the situation.

Possible Triggers:

- Exposure to loud noises
- Exposure to crowds
- Being in an unfamiliar environment
- Having daily routines disrupted

Possible Cues:

- Change in facial expressions
- Change in speech
- Change in movement
- Change in overall demeanor

Allocation of Space

To minimize triggers and cues, a separate space may be designated. The following points may be considered in the allocation and arrangement of the space.

- Quiet, private areas—far from media zone, entrance, etc
- Close access to electrical outlets and restrooms
- Sizeable area—anticipate parent(s) or other relatives accompanying the child
- Enclosed area for safety and security—away from doors
- Safe proofed areas—far from potential hazards such as windows, shelves, and book cases

Personnel

Hospitals need to anticipate that additional staffing may be required. Hospitals should pre-identify staff that have experience caring for children with access and functional needs. Another consideration is to establish recruitment pools for additional staff that who are qualified to care for children and leverage existing Child Life staff and volunteers. Unless urgent medical care is needed, most parents or caregivers have experience providing daily care for their child and know their habits and routines best. Parents and caregivers will be the best resource for caring for the child.

Special Dietary Needs

A number of children with access and functional needs have strict dietary requirements and unique eating habits, such as selective eating (see below), that may be compromised during a disaster. If a power outage were to occur, alternative means need to be implemented for food storage. Total parenteral nutrition (TPN) formula, blended foods, and other types of liquid feeding will need to be kept chilled.

Aside from food storage concerns, also prepare for feeding problems such as selective eating.

Selective eating by children with access and functional needs, like those with autism spectrum disorder (ASD), entail habits such as fearing new foods and preferring certain types of food due to brand, color, or texture.

Tech-dependency

Tech-dependent children with access and functional needs will need power. They need to be advised on the location of working electrical outlets. Additional power strips and batteries may need to be supplied.

Common medical devices used by children with access and functional needs include:

- ~~Tracheostomy tubes~~
- ~~Ventilators~~
- ~~Bi Level Positive Airway Pressure (BiPAP) machines~~
- ~~Continuous Level Airway Pressure (CPAP) machines~~
- ~~Central IV Catheters~~
- ~~Feeding Catheters~~
- ~~Gastronomy tubes~~
- ~~Nebulizers~~
- ~~High flow nasal cannula~~
- ~~Supplemental oxygen~~

Decontamination

Extra care and considerations need to be made for the decontamination of children with access and functional needs. Communication issues may restrict how directions are given and how much is understood. Misunderstanding the situation or the urgency for decontamination may greatly increase children's anxiety, and thus influence their cooperation, and potentially risk their safety. To mitigate this, hospitals may involve parents or caregivers in the process. It is important to keep the child and the guardian together, even if the guardian also needs to be decontaminated. In that situation, both may be decontaminated at the same station. Another consideration is whether or not the child uses a medical device or mobility aid. Devices and mobility aids that are non-porous and non-motorized may be decontaminated. Please note that some children may be completely dependent upon a mobility device that will not be eligible for decontamination due to their power source.

Reunification

The possibility of separation during an emergency or disaster may complicate the situation for children with access and functional needs that have conditions affecting their ability to communicate and understand. They may not be able to convey the necessary personal and medical information that is vital for identification in the reunification process. Some Children may also be fearful and distrustful of on-site personnel such as law enforcement and staff.

Preventive measures such as the use of an For children with special health care needs (CSHCN) the "Emergency Information Form" (EIF) is an important tool that will provide critical information and expedite care from the healthcare team. The EIF was endorsed by the (American College of Emergency Physicians (ACEP) and the American Academy of Pediatrics (AAP)) may reduce issues of identification and expedite care.

For more Additional information regarding the care of children with access and functional needs during a disaster please refer to pages 48-52.

| Unaccompanied Minor and Patient Tracking

The following table includes suggestions on caring for children with access and functional needs during an emergency or disaster. These recommendations have been compiled and adapted from various leading sources and agencies in the field of disaster preparedness.

COMMUNICATION -Alternative methods for children with access and functional needs

Sources: Marin County School District, National Emergency Management Association, and International Association of Emergency Managers

Recommendations

Additional Comments

■ Provide written materials should be available in different formats (e.g., Braille, large print, disks, and audio cassettes)

■ Hearing assistive technologies, auxiliary aids, and services such as sign language interpreters should be available.

■ Alarm systems for fire, etc. should have both audible and visual elements.

■ Pre-identify staff with foreign language and sign language skills and/or establish contracts with agencies who can support them.

■ Use pictures, symbols, and gestures to help communicate

■ Use electronic variable messaging boards, short message systems (SMS), teletypewriters (TTY) or telecommunications display devices (TDD)

■ Train staff and volunteers to practice basic American Sign Language (ASL) for emergency words

■ Suggested words: important, emergency, fire, keep calm, fire exit, stairs, and elevator

■ Screen all messages to ensure simplicity for understanding

■ All video and live television coverage should include captioning, ASL interpreters, and/or audio description

DECONTAMINATION – Considerations for children with access and functional needs

Sources: Marin County School District, National Emergency Management Association, and International Association of Emergency Managers

Recommendations	Additional Comments
<ul style="list-style-type: none">• Children may be allowed to ambulate through the line with assistance from either their parents or staff members. Children in wheelchairs may also move through the line in their chairs.	<ul style="list-style-type: none">• or children with mobility issues and with mobility aids that cannot move through the line, consider the use of wheeled shower chairs or backboards.
<ul style="list-style-type: none">• Note that children may be upset and feel uncomfortable with the removal of their assistive medical device and/or mobility aid, as well as the unfamiliar process and environment.	<ul style="list-style-type: none">• Speak slowly and calmly. Provide assurances about their safety and welfare
<ul style="list-style-type: none">• Allow additional time and effort during the process for children with visual and/or hearing impairments.	<ul style="list-style-type: none">• Provide descriptions about the environment and its physical layout• Incorporate parents or caregivers in the process to help create a sense of familiarity, provide positive contact, and assist with instructions
<ul style="list-style-type: none">• Plan for communication issues regarding sound and sight due to the PPE	<ul style="list-style-type: none">• Incorporate the use of visuals in your communication

GENERAL PREPAREDNESS – Considerations by needs type

Source: Marin County School District

Recommendations

Additional Comments

■ **Cognitive/Developmental:** These children may have difficulties understanding the situation and how to respond. Many conditions may lead to children having difficulty reading complicated directions for evacuation or response plans. Include visuals to assist non-reading or overstressed children. Make sure evacuation routes have directional signs that are easy to follow. Practice evacuation procedures and review route(s) regularly.

■ Suggested preparedness items are comfort items (e.g. stuffed animal), pen and paper, and visual communication instructions

■ **Hearing:** Pre-identify staff that are versed in sign language and provide other staff with sign language training. Staff should practice basic hand signals for emergency communications. Emergency alerting systems should also utilize non-audible components such as strobe lights and vibrating pagers.

■ Suggested preparedness items are pen and paper, flashlight, extra hearing aid batteries, and batteries for TTY and light phone signaler

■ **Mobility:** Children with limited mobility may face issues regarding evacuation and access. All furniture should be secured and arranged in a way to facilitate a barrier free route. If possible, keep a spare lightweight manual wheelchair for emergencies. Staff should be trained on how to properly transfer patients to and from wheelchairs. Also train and have mobility impaired patients practice wheelchair safety precautions such as locking their wheels and covering their heads and bodies.

■ Suggested preparedness items are: heavy gloves for making way over glass or debris, extra battery for wheelchairs, patch kit for punctured wheels, flashlight or headlight, and whistle

<p>● Respiratory: Children with respiratory impairments may have difficulty breathing when walking long distances or descending stairs during evacuation. Smoke, dust, fumes, chemicals, and other odors often exacerbate their conditions. For prevention purposes, emergency evacuation masks and respirators as well as other oxygen and respiratory equipment should be available for distribution. Have patients and staff practice putting on and removing this equipment as part of an emergency drill.</p>	<p>■ Suggested preparedness items are medical masks, and any medical equipment needed for 72 hours, and paper and pen</p>
<p>● Speech/Auditory: Pre-identify the patient's preferred method of communication and whether or not it is effective. Also, provide patients with a filled-out emergency card and evacuation instructions on a card to be carried at all times and placed in an easy-to-see location.</p>	<p>● Suggested preparedness items are extra batteries for communication equipment, paper and pen, and comfort items. Suggested preparedness items are:</p>
<p>■ Visual: During an evacuation, assistance from others may be needed for patients with visual impairments. Provide Braille signage or audible directions for patients who are blind or have low vision. Having emergency backup lighting systems, especially in stairwells and other dark areas, can also help patients with limited visual acuity. All emergency supplies and materials should be marked with large print or Braille. Have patients practice describing their surroundings.</p>	<p>■ Suggested preparedness items are extra folding white cane, heavy gloves, colored clothing item for visibility, and comfort items</p>

History and Summary of Revisions

History

The initial needs assessment and gap analysis for the Los Angeles County EMS Agency Pediatric Surge Plan were conducted in 2011. The LAC EMS Agency Pediatric Surge Plan was initially approved in May 2013.

Summary of Revisions

September 2015

The following edits were made to the original LAC EMS Agency Pediatric Surge Plan after the completion of the Pediatric Surge Tabletop and Functional Exercises held on April 20, 2015 and June 11, 2015 respectively.

- The original Tier 1 hospitals were separated into trauma centers and non-trauma medical centers and are now classified as Tier 1 and Tier 2, respectively. These classifications are assigned based on the resources available at the hospital. This alteration addresses issues of Tier 1 non-trauma hospitals receiving pediatric patients who need specialized trauma care, which became apparent during pre-exercise planning and the exercise in June 2015. The remaining tiers are reorganized to reflect the addition of the non-trauma medical center category, such that the existing Tier 2 becomes Tier 3, and so on.
- The overall surge capacity has changed by five (5) pediatric intensive care unit (PICU) beds and 50 pediatric acute care beds due to the following:
 - The loss of EDAP status for Southern California Hospital Culver City and San Gabriel Valley Medical Center. Both of these hospitals are now classified as Tier 5 and each have a pediatric acute surge capacity of five beds. This is a reduction from the Tier 4 capacity of 15 Acute beds per hospital; the total loss of capacity is 20 pediatric acute care surge beds.
- The Pediatric Surge Plan was reorganized so that the plan is more concise.
 - The Pediatric Surge Plan was revised into a shorter document for ease of use and revision.
 - Background, Current Status, Initial Needs Assessment, and Gap Analysis were moved to the Appendices.
 - The training section was moved to the Appendices.
- Appendices B, D, E, H, I, and J were added.

Ongoing

Individual hospital designations and status changes will be updated annually in **Appendix A.**

Contributors to the ~~2015-16~~~~2023-2024~~ EMS Agency ~~Pediatric Surge Plan~~Pediatric Acute Surge Plan Update

Los Angeles County Emergency Medical Services Agency thanks the following contributors to the updates of the LA County ~~Pediatric Surge Plan~~Pediatric Acute Surge Plan.

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~~Contributors to the 2022~~ Pediatric Acute Surge Plan Update

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[Federal Award Identification Number \(FAIN\) U3REP240735 \(2024\)](#)

SUBJECT: **AMBULANCE PATIENT OFFLOAD TIME (APOT)** REFERENCE NO. 505

PURPOSE: To establish a policy for the safe and rapid transfer of patient care responsibilities from emergency medical services (EMS) personnel to emergency department (ED) medical personnel.

AUTHORITY: California Health and Safety Code, Division 2.5 Sections 1797.120, 1797.225

DEFINITIONS:

Ambulance patient offload time (APOT): Time interval between the arrival of an ambulance at the location outside the hospital ED where the patient will be unloaded from the ambulance and the time the patient is transferred to the ED gurney, bed, chair or other acceptable location and the ED assumes responsibility for the care of the patient (facility equipment time). The APOT Standard in Los Angeles County is within 30 minutes, 90% of the time. Currently, the data source for APOT is the EMS Providers' electronic patient care report completed by the transporting unit.

Facility Equipment Time: The time the patient is transferred to the ED gurney, bed, chair or other acceptable location and the ED assumes responsibility for the care of the patient.

PRINCIPLES:

1. As per the Emergency Medical Treatment & Labor Act (EMTALA), the responsibility for patient care lies with the receiving facility once the patient arrives at the hospital property.
2. Hospitals have the responsibility to ensure policies and processes are in place that facilitate the rapid and appropriate transfer of patient care from EMS personnel. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.
3. Extended APOT is a healthcare system and hospital throughput issue. Extended APOT negatively impacts EMS providers' ability to respond to subsequent 9-1-1 calls resulting in delayed response times and may affect public safety and patient outcomes.
4. Each hospital shall have a policy and a multidisciplinary team-based approach to ensure the ability of the facility to remain open to accept patients arriving by ambulance in the ED.
5. Hospitals that have extended APOT should assign appropriate personnel to remain with patients while waiting for an ED treatment bay in order to release EMS personnel back to the community.
6. The State of California Emergency Medical Services Authority has adopted Standardized Methods for Data Collection and Reporting of APOT which has been adopted by Los Angeles County.

EFFECTIVE DATE: 11-01-22
REVISED: 07-01-23
SUPERSEDES: 11-01-22

PAGE 1 OF 5

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

7. The accurate documentation by EMS professionals of the time metrics for APOT is imperative to appropriately evaluate and monitor APOT.

POLICY:

I. Responsibilities of Hospital ED Personnel to Mitigate Extended APOT

- A. Immediately acknowledge EMS patient arrival and provide visual assessment; receive verbal patient report as soon as possible upon arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the ED to await urgent or emergency care.
- ~~B.~~ Transfer patient to the hospital gurney, bed, chair, wheelchair or waiting room as appropriate for patient condition within 30 minutes of arrival at the ED.
- ~~B-C.~~ Confirm with EMS personnel the “facility equipment time” to be documented on the ePCR of the EMS personnel.
- ~~C-D.~~ If unable to immediately offload patient, provide a safe area in the ED within direct sight of ED medical personnel where the EMS personnel can temporarily wait while hospital’s patient remains on the ambulance gurney.
- ~~D-E.~~ Inform the ambulance transport crew of the anticipated time for the offload of the patient.
- ~~E-F.~~ For extended APOT, provide information to the onsite supervisor of EMS personnel regarding the steps that are being taken by the hospital to resolve extended APOT.
- ~~F-G.~~ Notify the Nursing Supervisor/Administrator on Duty that the ED is experiencing extended APOT and request assistance with patient throughput challenges.

II. Responsibilities of EMS Personnel to Mitigate Extended APOT

- A. Upon arrival at ED, EMS personnel will present to the customary ambulance receiving area for a triage assessment by assigned ED staff (e.g., charge nurse).
- B. Provide a verbal patient report to assigned ED staff, transfer patient to hospital equipment as directed by ED staff.
- C. If the APOT estimate is ≥ 30 minutes, and the patient meets **ALL** criteria listed below, EMS personnel will inform the appropriate ED staff (e.g., charge nurse) that the patient will be offloaded in the waiting room. EMS personnel shall provide a transfer of care report to the appropriate ED staff (e.g., triage nurse).
1. Age 18 years or older; or pediatric patients if accompanied by an adult
 2. Normal mental status (GCS 15)
 3. Normal vital signs upon arrival to the ED per Ref. No. 1380 for adults
 - SBP ≥ 90 mmHg
 - HR 60-100
 - RR 12-20

- O2 Saturation $\geq 94\%$ on room air
 - Or per Ref. No. 1309 for pediatrics
4. Ambulatory with steady gait without assistance (as appropriate for age)
 5. Without suicidal ideation or suspected substance abuse and not on psychiatric hold (i.e., 5585 (pediatric), 5150 (adult))
 6. No chest pain, syncope, or acute neurologic symptoms (e.g., focal weakness, dizziness/vertigo)
 7. No ongoing ALS intervention required
 8. Patients who received medications that may require ongoing reassessment (e.g., naloxone, narcotics, epinephrine) shall be discussed with the appropriate ED staff (e.g., triage nurse) prior to being offloaded in the waiting room.
- D. If APOT estimate is > 30 minutes and the patient does not meet the criteria listed in II. C., each individual EMS personnel (EMT or Paramedic), in order to facilitate EMS field operations, may observe up to 4 patients within their scope of practice at the discretion of the EMS provider's supervisor, while awaiting patient offload to facility equipment.
1. Coordination will be done by the EMS Provider agency's on-site supervisor to identify the EMS personnel who will monitor patients awaiting transfer of care to ED staff and those that may be released to accept other emergency calls.
 2. Hospitals should provide gurneys or cots for these patients, to allow EMS personnel to maintain their field operations.
 3. EMS Provider agency's on-site supervisor may authorize the placement of temporary cots to house EMS patients being observed by EMS personnel awaiting transfer of care to ED staff.
- E. Document the "facility equipment time" on the electronic patient care record (ePCR) to capture the time patient care is transferred to ED personnel. [This shall be done in consultation with hospital licensed personnel accepting responsibility for the care of the patient.](#)
- F. Notify EMS Supervisor if Provider ALS Diversion Threshold is met as defined in Ref. No. 503.1.
- III. Responsibilities of the EMS Agency
- A. The EMS Agency will routinely analyze and report APOT data. Hospitals that do not meet the APOT Standard will be notified and may be requested to develop a corrective action plan.
 - B. At any given time, the EMS Agency via the Medical Alert Center (MAC) will establish phone notification with hospital administration in instances wherein 3 or more ambulance transport crew are waiting to offload for time periods of 30 minutes or more.
-

- C. After an evaluation of a hospital’s status and regional/system resources, the EMS Agency via the MAC may place a hospital on Specialty Care Center Diversion (e.g., Trauma, STEMI, Stroke) in addition to ED ALS and/or ED BLS Diversion in instances wherein the APOT is estimated to exceed 2 hours.
- D. In instances whereby extended APOT threatens public health and safety by preventing EMS response to emergency medical incidents, the EMS Agency, with appropriate notification to hospital, may authorize EMS personnel provided the patient meets **ALL** the criteria listed in II.C to:
 - 1. Inform ED medical personnel that they are transitioning patient care **and**
 - 2. Immediately offload patient to a hospital bed or other suitable hospital sitting or reclining device as appropriate for patient condition.

In these instances, EMS personnel shall make every attempt to notify ED Charge Nurse that they must immediately return to service. EMS personnel shall provide a verbal transfer of care report to ED medical personnel.
- E. Procedure for requesting corrective action plan from hospitals that have persistent delays in APOT

Month	Action 1	Audit Result	Action 2
1 st	EMS Agency audits Hospital’s compliance with APOT Standard.	Hospital consistently demonstrate prolonged APOT, and EMS Providers have consistently requested to place Hospital on ALS and/or BLS Diversion	EMS Agency notifies hospital’s ED Director and ED Nurse Manager, via email or telephone, of audit results, requests corrective action plan and assists in determining solutions.
2 nd	EMS Agency re-evaluates Hospital’s compliance with APOT Standard.	Hospital fails to demonstrate incremental improvement in APOT.	EMS Agency sends a written notice to Hospital’s ED Director and Nurse Manager notifying them of the audit results and their non-compliance.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
3 rd	EMS Agency re-evaluates Hospital’s compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	EMS Agency notifies Hospital’s CEO in writing of audit results and request a corrective action plan be submitted within 15 calendar days.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.

Month	Action 1	Audit Result	Action 2
4 th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	Within 15 days of the EMS Agency's receipt of Hospital's corrective action plan, a written approval or request additional modifications to the plan.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
5 th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT.	EMS will request modification to Hospital's corrective action plan.
		Hospital implements corrective action plan and demonstrates improvement in APOT.	Monitor to ensure Hospital maintains improvement in APOT.
6 th	EMS Agency re-evaluates Hospital's compliance with APOT Standard.	Hospital continues to fail to demonstrate incremental improvement in APOT	See Policy III.F.
		Hospital's compliance threshold improves.	Monitor to ensure Hospital maintains improvement in APOT.

- F. Failure of a hospital to implement corrective action plan to improve APOT six months after initial request from EMS to implement corrective action plan may result in additional action from the EMS Agency, which may include but not limited to:
1. Reduction in 9-1-1 transports to hospital
 2. Temporary suspension of Specialty Care Center Designation
 3. Others as identified

CROSS REFERENCE:

Prehospital Care Manual:

Ref. No. 503.1, **Diversion Request Requirements for Emergency Department Saturation**

California EMSA: Ambulance Patient Offload Time (APOT) Standardized Methods for Data Collection and Reporting

Classification

Synthetic B12, anti-anemic

LA County Prehospital Indications

Cyanide toxicity: cardiovascular, neurologic, and/or respiratory compromise due to suspected or known cyanide exposure

Other Common Indications (Not authorized for EMS administration in LA County)

B12 deficiency

Adult Dose

5 grams (25mg/ml) reconstituted in 200mL of Normal Saline IV/IO and infused over 15 minutes, may repeat x1 in 15 minutes

Pediatric Dose

70mg/kg (25mg/ml) infused over 15 minutes [reconstitute 5 grams in 200mL of Normal Saline and infuse weight-based dose], may repeat x1 in 15 minutes

Mechanism of Action

Contains cobalt compounds that bind to and detoxify cyanide thereby preventing its binding to cytochrome c oxidase which leads to inhibition of cellular respiration.

Pharmacokinetics

Onset immediate

Duration half-life 24 hours

Contraindications

Hypersensitivity

Interactions

Sodium thiosulfate, sodium nitrite

Adverse Effects

Allergic reactions

Renal injury

Increase in blood pressure

Prehospital Considerations

- Do not co-administer with other medications through the same vascular access; flush in between.
- Avoid administration through the same IV/IO as blood products.
- After administration pulse oximetry and co-oximetry will be inaccurate and may overestimate oxygenation and underestimate CO exposure. Skin, tears and urine will turn red; flushing is expected.
- Hydroxocobalamin may interfere with laboratory tests for up to 24 hours.

SUBJECT: **LOS ANGELES COUNTY PARAMEDIC
SCOPE OF PRACTICE**

PURPOSE: To define the scope of practice of a paramedic accredited in Los Angeles County.

AUTHORITY: California Health and Safety Code, Division 2.5, Section 1797.172
California Code of Regulations, Title 22, Chapter 4, Section 100145.

DEFINITION:

Los Angeles County Paramedic Scope of Practice: Skills, procedures, and medication administration approved by the Los Angeles County EMS Agency Medical Director.

PRINCIPLES:

1. Paramedics working in Los Angeles County shall be trained and tested in the Los Angeles County paramedic scope of practice approved by the EMS Agency Medical Director.
2. Procedures or medications may be added as part of the Los Angeles County scope of practice or through a trial study.
3. A paramedic may perform any activity identified in Ref. No. 802, Los Angeles County EMT Scope of Practice.
4. Paramedics shall be licensed in the State, accredited by the County, employed, and sponsored by an approved paramedic service provider. The paramedic shall be on duty in order to perform the Los Angeles County paramedic scope of practice.
5. Advanced life support activities carried out by paramedics at the scene of a medical or trauma emergency or during transport shall be under the following conditions:
 - a. Offline medical control following Ref. No. 1200, Treatment Protocols, et al.
 - b. Online medical direction by a base hospital physician or Mobile Intensive Care Nurse (MICN)
 - c. Direct medical supervision as outlined in Ref. No. 816, Physician at the Scene.

POLICY:

- I. A Los Angeles County accredited paramedic or a supervised paramedic intern is authorized to perform and utilize all aspects of the Los Angeles County Paramedic Scope of Practice during training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfers.

EFFECTIVE: 03-01-86

PAGE 1 OF 4

REVISED: 12-01-23 (or effective upon implementation of EMS Update 2023)

SUPERSEDES: 04-01-23

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

The paramedic scope of practice includes Ref. No. 802, Los Angeles County EMT Scope of Practice, in addition to the following:

- A. Patient assessment:
 - 1. Use capnometry and measuring devices to measure capnography waveforms
 - 2. Utilize electrocardiographic devices and monitor electrocardiogram, including 12-lead electrocardiograms (ECG) per Ref. No. 1308, Medical Control Guideline: Cardiac Monitoring / 12-Lead ECG
 - 3. Obtain venous or capillary blood samples
 - 4. Use electronic devices to measure glucose
- B. Airway management and monitoring:
 - 1. Use basic and advanced airway maneuvers as per Ref. No. 1302, Medical Control Guideline: Airway Management and Monitoring
 - 2. Utilize mechanical ventilation devices for continuous positive airway pressure per Ref. No. 1315, Medical Control Guideline: Continuous Positive Airway Pressure (CPAP)
- C. Rescue and emergency care:
 - 1. Perform needle thoracostomy per Ref. No. 1335, Medical Control Guideline: Needle Thoracostomy
 - 2. Perform defibrillation
 - 3. Perform synchronized cardioversion
 - 4. Perform transcutaneous pacing per Ref. No. 1365, Medical Control Guideline: Transcutaneous Pacing (TCP)
 - 5. ~~Utilize hemostatic dressings per Ref. No. 1370, Medical Control Guideline: Traumatic Hemorrhage Control~~
 - 6.5. Utilize Valsalva maneuver
 - 7.6. Monitor thoracostomy tubes
 - 8.7. Monitor blood product transfusions
- D. Intravenous, intraosseous and pre-existing vascular access devices (PVAD) per Ref. No. 1375, Medical Control Guideline: Vascular Access
- E. Medication Administration:
 - 1. Administer approved medications by the following routes:

- a. Oral
 - b. Intranasal
 - c. Sublingual
 - d. Transcutaneous
 - e. Topical
 - f. Inhalation
 - g. Rectal
 - h. Intravenous
 - i. Intraosseous
 - j. Intramuscular
 - k. Subcutaneous
2. Administer and/or monitor the following medications (using pre-packaged unit dose products when available):
- a. 10%, 25%, and 50% dextrose
 - b. adenosine
 - c. aerosolized/nebulized albuterol by hand held nebulizer or hand held mask
 - d. amiodarone
 - e. aspirin
 - f. atropine sulfate
 - g. blood products (monitoring transfusion)
 - h. calcium chloride
 - i. diazepam (*disaster caches only*)
 - j. diphenhydramine hydrochloride
 - k. epinephrine
 - l. fentanyl
 - m. glucagon

n. hydroxocobalamin

o. ketorolac

n-p. lidocaine

o-q. midazolam

p-r. morphine sulfate

q-s. naloxone hydrochloride

r-t. normal saline solution

s-u. nitroglycerin tablet or spray

t-v. olanzapine

u-w. ondansetron

v-x. potassium, equal to or less than 40meq/L (*transport infusion only*)

w-y. pralidoxime chloride (2-PAMCI)

x-z. sodium bicarbonate

y-aa. total parenteral nutrition (*transport infusion only*)

z-bb. tranexamic acid

II. Trial Studies

Procedures or medications may be implemented on a trial basis when approved by the Medical Director of the EMS Agency.

CROSS REFERENCES:

Prehospital Care Manual:

Ref. No. 802, **EMT Scope of Practice**

Ref. No. 802.1, **Los Angeles County EMT Scope of Practice**

Ref. No. 803.1, **Los Angeles County Paramedic Scope of Practice**

Ref. No. 816, **Physician at the Scene**

Ref. No. 830, **Paramedic Trial and Scientific Studies**

Ref. No. 1006, **Paramedic Accreditation, Continuous Accreditation, and Reaccreditation**

MCG. No. 1333, **Monitoring Transfusion of Blood Products**

<i>IN ADDITION TO THE FOLLOWING, THE PARAMEDIC SCOPE OF PRACTICE INCLUDES REFERENCE No. 802, LOS ANGELES COUNTY EMT SCOPE OF PRACTICE</i>	
PATIENT ASSESSMENT	MEDICATION ADMINISTRATION
<ol style="list-style-type: none"> 1. Use capnometry and measuring devices to measure capnography waveforms 2. Utilize electrocardiographic devices and monitor electrocardiograms (ECG), including 12-lead ECGs 3. Obtain venous or capillary blood samples 4. Use electronic devices to measure glucose 	<ol style="list-style-type: none"> 1. Administer approved medications by the following routes: <ol style="list-style-type: none"> a. oral b. intranasal c. sublingual d. transcutaneous e. topical f. inhalation g. rectal h. intravenous i. intraosseous j. intramuscular k. subcutaneous 2. Administer the following medications (using pre-packaged unit dose products when available): <ol style="list-style-type: none"> a. 10%, 25%, and 50% dextrose b. adenosine c. aerosolized/nebulized albuterol by handheld nebulizer or handheld mask d. amiodarone e. aspirin f. atropine sulfate g. calcium chloride h. diazepam (<i>disaster caches only</i>) i. diphenhydramine hydrochloride j. epinephrine k. fentanyl l. glucagon m. <u>hydroxocobalamin</u> nn. ketorolac no. <u>lidocaine</u><u>midazolam</u> op. <u>midazolam</u> <u>morphine sulfate</u> pg. <u>morphine sulfate</u> <u>naloxone hydrochloride</u> qr. <u>naloxone hydrochloride</u> <u>nitroglycerin tablet or spray</u> rs. <u>nitroglycerin tablet or spray</u> <u>olanzapine</u> st. <u>olanzapine</u> <u>ondansetron</u> tu. <u>ondansetron</u> <u>pralidoxime chloride (2-PAMCl)</u> uv. <u>pralidoxime chloride (2-PAMCl)</u><u>sodium bicarbonate</u> wv. <u>sodium bicarbonate</u> <u>tranexamic acid (TXA)</u> wx. <u>tranexamic acid (TXA)</u>
AIRWAY MANAGEMENT & OXYGEN ADMINISTRATION	
<ol style="list-style-type: none"> 1. Use a laryngoscope to visualize the airway and remove a foreign body with Magill forceps 2. Insert and perform pulmonary ventilation by use of: <ol style="list-style-type: none"> a. supraglottic airway (i-gel) in adult and pediatric patients b. oral endotracheal intubation in adults and pediatric patients over the age of twelve (12) or height greater than the length of the pediatric resuscitation tape c. stomal intubation 3. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP). 	
RESCUE & EMERGENCY CARE	
<ol style="list-style-type: none"> 1. Perform needle thoracostomy 2. Perform defibrillation 3. Perform synchronized cardioversion 4. Perform transcutaneous pacing for symptomatic bradycardia 5. <u>Utilize hemostatic dressings</u> 6. Utilize Valsalva maneuver 7. Monitor thoracostomy tubes 8. Monitor blood product transfusions 	
INTRAVENOUS & INTRAOSSEOUS ACCESS	
<ol style="list-style-type: none"> 1. Insert intravenous (IV) catheters, saline locks, or needles in peripheral veins 2. Monitor and administer medications and IV fluids through external venous pre-existing vascular access devices (PVADs) in the following: <ol style="list-style-type: none"> a. cardiac arrest b. extremis due to circulatory shock c. base station order 3. Monitor and administer normal saline solution 4. Monitor and adjust IV solutions of potassium, maximum 40mEq/L 5. Monitor total parenteral nutrition (TPN) 6. Perform adult and pediatric intraosseous insertion per Ref. No. 1375 	
	TRIAL STUDIES
	Procedures or medications may be implemented on a trial basis when approved by the Medical Director of the EMS Agency.
	CROSS REFERENCES:

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **LOS ANGELES COUNTY
PARAMEDIC SCOPE OF PRACTICE**

REFERENCE 803.1

<p>7.—Obtain venous or capillary blood samples</p>	<p>Prehospital Care Manual: Ref. No. 802 Ref. No. 802.1 Ref. No. 803 Ref. Series 1200s Ref. Series 1300s</p>
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Base Hospital Contact: Required for severe respiratory distress unresponsive or not amenable to CPAP.

1. Assess scene for safety
2. Use appropriate PPE
3. Remove patient from environment if potential for ongoing exposure
4. Assess airway and initiate basic and/or advanced airway maneuvers [prn \(MCG 1302\)](#)
5. If patient awake and alert, place in position of comfort
6. Administer **Oxygen** [prn \(MCG 1302\)](#)
High flow Oxygen 15 L/min for all patients with smoke inhalation, carbon monoxide exposure, or severe respiratory distress due to airway injury, regardless of SpO₂ ❶
7. If patient has an Unmanageable Airway [\(MCG 1302\)](#)
Initiate immediate transport to the MAR and **CONTACT BASE** en route
8. Assess for signs of trauma
If traumatic injury suspected, treat in conjunction with [TP 1244, Traumatic Injury](#)
9. For airway burns, treat in conjunction with [TP 1220, Burns](#)
10. For suspected carbon monoxide exposure, treat in conjunction with [TP 1238, Carbon Monoxide Poisoning](#)
11. For suspected exposure to hazardous materials including cyanide toxicity, treat in conjunction with [TP 1240, HAZMAT](#)
12. For airway edema and/or stridor:
Epinephrine (1mg/mL solution) administer 5mg (5mL) via neb
Repeat x1 in 10 min prn
13. For wheezing/bronchospasm (consider also for cough):
Albuterol 5mg (6mL) via neb or 4 puffs via MDI
Repeat x2 prn, maximum total dose prior to Base contact 15mg
14. Initiate CPAP for alert patients with moderate or severe respiratory distress
Hold CPAP for patients with hypotension, suspected pneumothorax, upper airway edema/obstruction, or other contraindications [\(MCG 1315\)](#) ❷

15. Initiate cardiac monitoring prn (*MCG 1308*)
16. Perform 12-lead ECG if cardiac ischemia suspected (*MCG 1308*)
17. Establish vascular access prn (*MCG 1375*)
18. For poor perfusion (*MCG 1355*):
Normal Saline 1L IV rapid infusion
Reassess after each 250mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

For persistent poor perfusion, treat in conjunction with *TP 1207, Shock/Hypotension*

SPECIAL CONSIDERATIONS

- ① Suspect smoke inhalation and carbon monoxide exposure in setting of closed-space fires, carbonaceous sputum in mouth/nose, elevated carbon monoxide levels (if point of care testing available), and facial burns. For patients with ALOC or seizure after industrial or closed space fire, also consider cyanide toxicity; contact Base and ensure notification of the receiving hospital.

- ② CPAP is appropriate for undifferentiated respiratory distress and may be used if patient does not improve after initial albuterol.



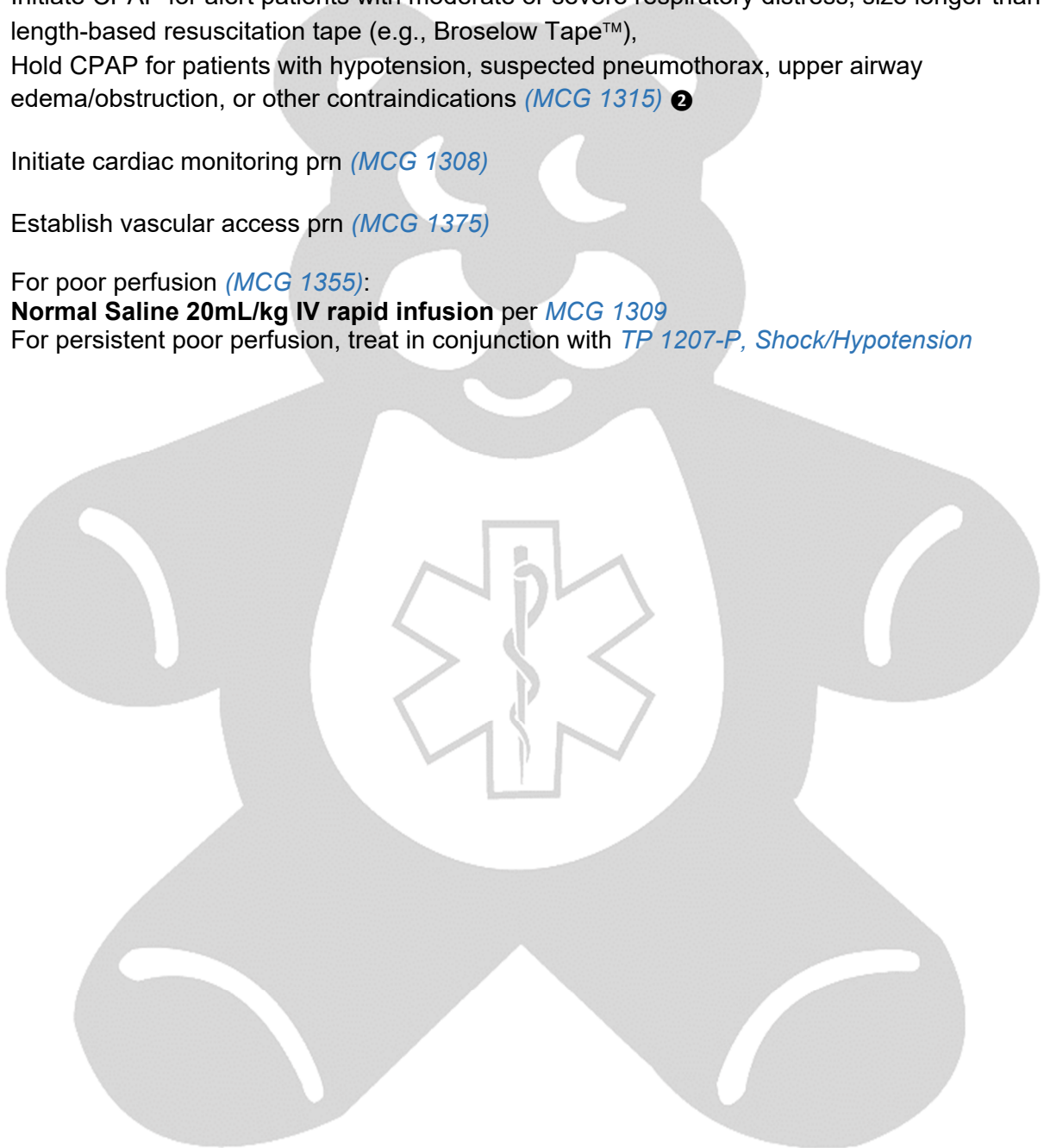
Base Hospital Contact: Required for severe respiratory distress unresponsive or not amenable to CPAP

1. Assess scene for safety
2. Use appropriate PPE
3. Remove from environment if potential for ongoing exposure
4. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
5. If patient awake and alert, place in position of comfort
6. Administer **Oxygen** prn (*MCG 1302*)
High-flow Oxygen 15L/min for all patients with smoke inhalation, carbon monoxide exposure, or severe respiratory distress due to airway injury, regardless of SpO₂ ①
7. Advanced airway prn (*MCG 1302*)
8. If patient has an Unmanageable Airway (*MCG 1302*)
Initiate immediate transport to the EDAP and **CONTACT BASE**
9. Assess for signs of trauma
If traumatic injury suspected, treat in conjunction with *TP 1244-P, Traumatic Injury*
10. For airway burns, treat in conjunction with *TP 1220-P, Burns*
11. For suspected carbon monoxide exposure, treat in conjunction with *TP 1238-P, Carbon Monoxide Poisoning*
12. For suspected exposure to hazardous materials including cyanide toxicity, treat in conjunction with *TP 1240-P, HAZMAT*
13. For airway edema and/or stridor:
< 1 year old: **Epinephrine (1mg/mL) 2.5mL via neb** per *MCG 1309* ①
≥ 1 year of age: **Epinephrine (1mg/mL) 5mL via neb** per *MCG 1309* ①
Repeat x1 in 10 min prn
14. For wheezing/bronchospasm (consider also for cough):
< 4 year of age: **Albuterol 2.5mg (3mL) via neb** per *MCG 1309* ①
≥ 4 year of age: **Albuterol 5mg (6mL) via neb** per *MCG 1309* ①
Repeat x2 prn



CONTACT BASE for additional Albuterol after maximum dose administered

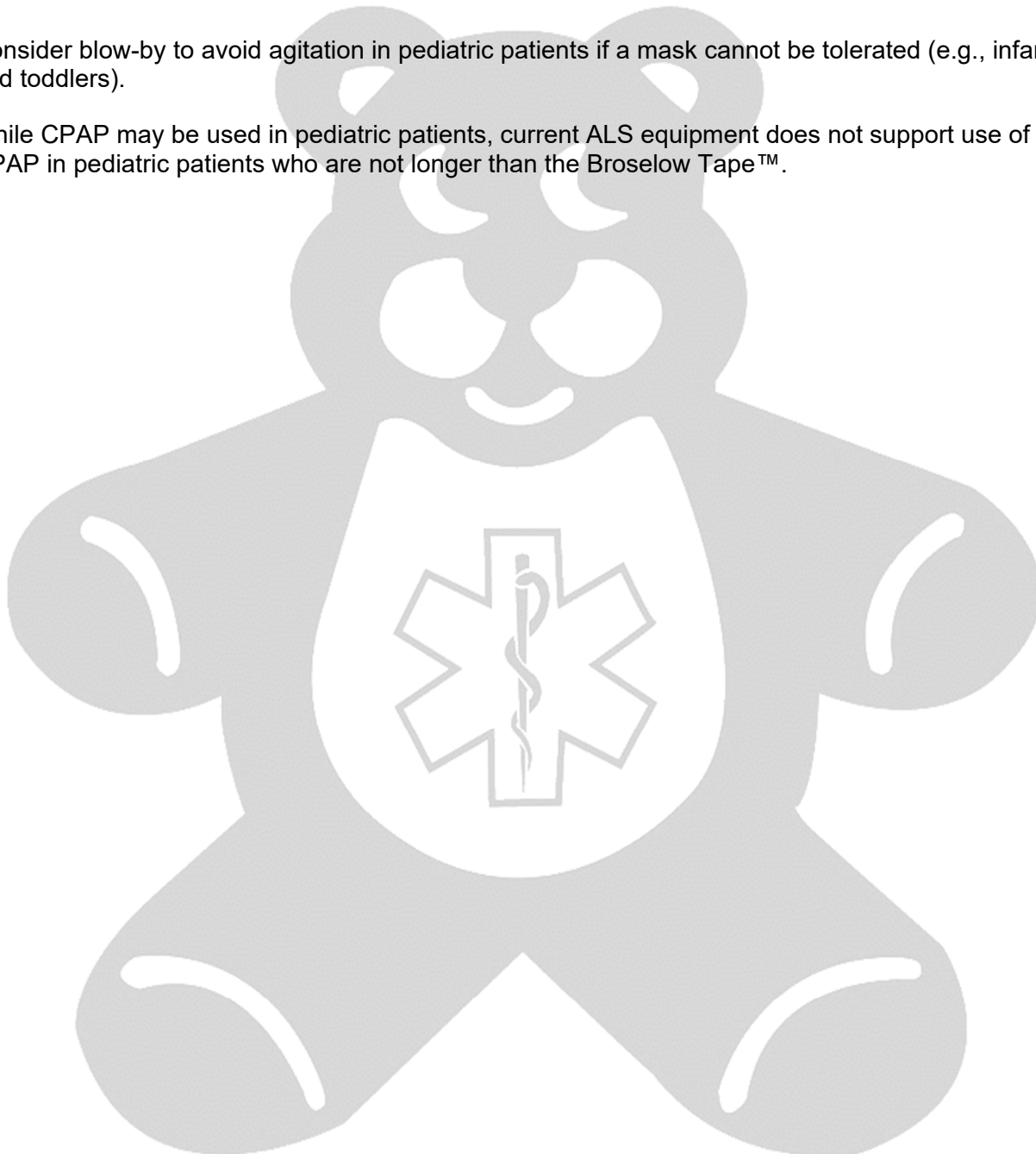
15. Initiate CPAP for alert patients with moderate or severe respiratory distress, size longer than the length-based resuscitation tape (e.g., Broselow Tape™),
Hold CPAP for patients with hypotension, suspected pneumothorax, upper airway edema/obstruction, or other contraindications [\(MCG 1315\)](#) ②
16. Initiate cardiac monitoring prn [\(MCG 1308\)](#)
17. Establish vascular access prn [\(MCG 1375\)](#)
18. For poor perfusion [\(MCG 1355\)](#):
Normal Saline 20mL/kg IV rapid infusion per [MCG 1309](#)
For persistent poor perfusion, treat in conjunction with [TP 1207-P, Shock/Hypotension](#)





SPECIAL CONSIDERATIONS

- ❶ Consider blow-by to avoid agitation in pediatric patients if a mask cannot be tolerated (e.g., infants and toddlers).
- ❷ While CPAP may be used in pediatric patients, current ALS equipment does not support use of CPAP in pediatric patients who are not longer than the Broselow Tape™.



1. Assess scene for potential hazards and number of patients
2. Remove patient from the source of carbon monoxide ❶
3. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
4. Administer **high flow Oxygen 15 L/min** (*MCG 1302*)
5. Initiate cardiac monitoring prn (*MCG 1308*)
Perform 12-lead ECG to assess for cardiac ischemia ❷
6. If carbon monoxide monitor available, consider measuring CO level ❸
Report and document results
7. Establish vascular access prn (*MCG 1375*)
8. For altered level of consciousness, treat in conjunction with *TP 1229, ALOC*
9. Assess for signs of trauma
For traumatic injury, treat in conjunction with *TP 1244, Traumatic Injury*
10. For poor perfusion (*MCG 1355*):
Normal Saline 1L IV rapid infusion
Reassess after each 250mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

For persistent poor perfusion, treat in conjunction with *TP 1207, Shock/Hypotension*
11. For suspected exposure to hazardous materials including cyanide toxicity, treat in conjunction with *TP 1240, HAZMAT* ❹

SPECIAL CONSIDERATIONS

- ① Symptoms of carbon monoxide poisoning include headache, altered level of consciousness, malaise, nausea, dizziness and unresponsiveness. Consider carbon monoxide when multiple persons in same location present with any of these symptoms.
- ② Patients with carbon monoxide poisoning have impaired oxygen delivery and are at high risk for cardiac ischemia.
- ③ The measured CO level should not impact the transport decision. It will be helpful for hospital treatment of the exposure.
- ④ Exposures to certain chemicals can be associated with carbon monoxide poisoning. For example, methylene chloride (dichloromethane) is an industrial solvent and a component of paint remover. It is metabolized to carbon monoxide by the liver and may cause carbon monoxide toxicity if inhaled or ingested.



Treatment Protocol: CARBON MONOXIDE EXPOSURE

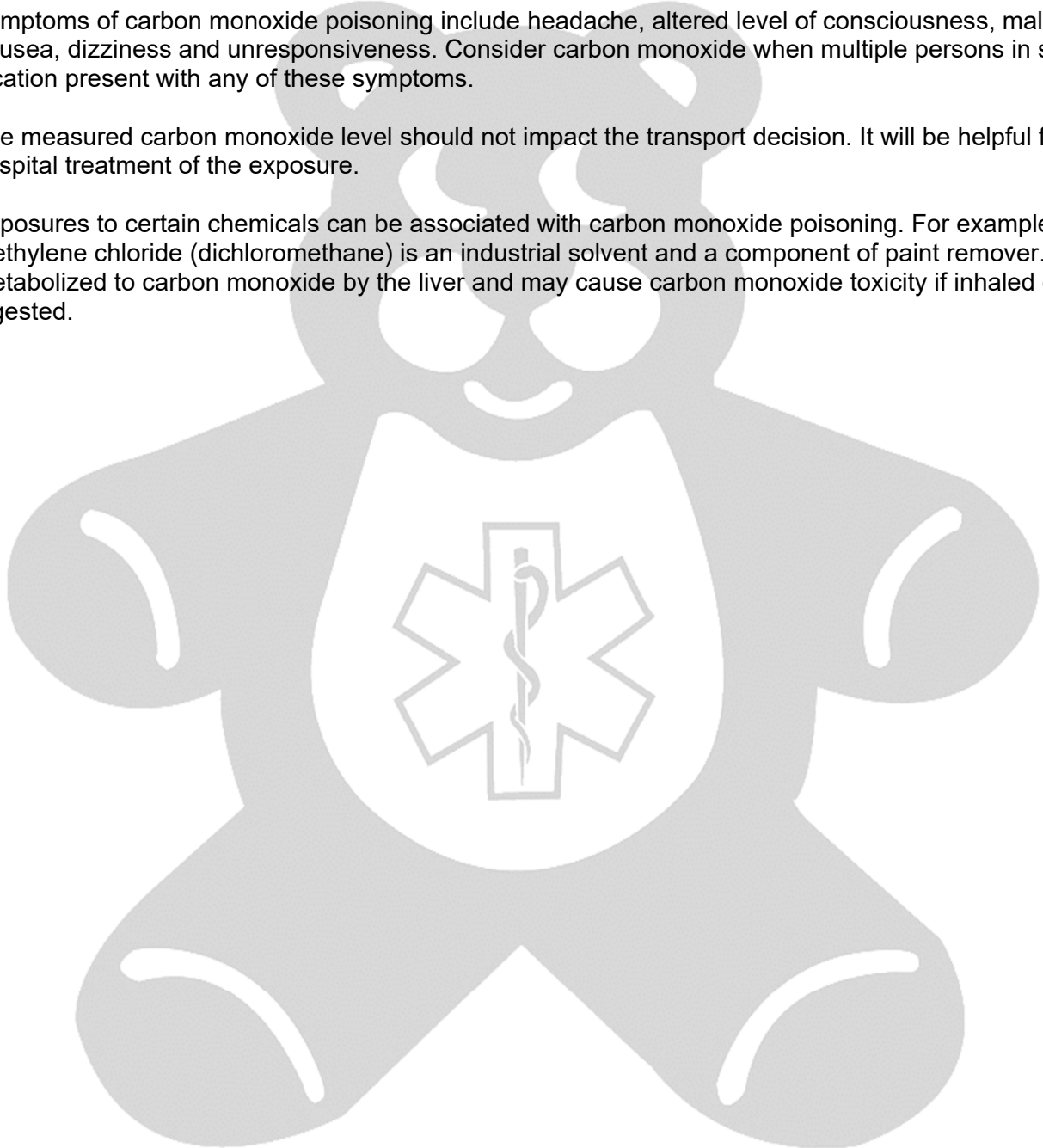
Ref. No. 1238-P

1. Assess scene for potential hazards and number of patients
2. Remove patient from the source of carbon monoxide ❶
3. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
4. Administer **high-flow Oxygen 15 L/min** (*MCG 1302*)
5. Initiate cardiac monitoring prn (*MCG 1308*)
6. If carbon monoxide monitor available, consider measuring CO level ❷
Report and document results
7. Establish vascular access prn (*MCG 1375*)
8. For altered level of consciousness, treat in conjunction with *TP 1229-P, ALOC*
9. Assess for signs of trauma
For traumatic injury, treat in conjunction with *TP 1244-P, Traumatic Injury*
10. For poor perfusion (*MCG 1355*):
Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*
For persistent poor perfusion, treat in conjunction with *TP 1207-P, Shock/Hypotension*
11. For suspected exposure to hazardous materials including cyanide toxicity, treat in conjunction with *TP 1240-P, HAZMAT* ❸



SPECIAL CONSIDERATIONS

- ❶ Symptoms of carbon monoxide poisoning include headache, altered level of consciousness, malaise, nausea, dizziness and unresponsiveness. Consider carbon monoxide when multiple persons in same location present with any of these symptoms.
- ❷ The measured carbon monoxide level should not impact the transport decision. It will be helpful for hospital treatment of the exposure.
- ❸ Exposures to certain chemicals can be associated with carbon monoxide poisoning. For example, methylene chloride (dichloromethane) is an industrial solvent and a component of paint remover. It is metabolized to carbon monoxide by the liver and may cause carbon monoxide toxicity if inhaled or ingested.



Contact Medical Alert Center (MAC) for all MCIs prior to transport otherwise notify the receiving hospital.

1. Secure area, establish incident site, and don protective equipment/gear appropriate for hazardous material exposure according to the provider agency protocol
2. If MCI, begin triage (*Ref. 519.2 and Ref. 519.5*)
Provide MAC with the following incident information: properties of contaminant, type of decontamination performed, signs/symptoms, and smells
3. Remove patient from source if safe to do so, and move to decontamination area prn
4. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
5. Administer **Oxygen** prn (*MCG 1302*)
6. Remove patient's clothing
7. Flush skin, eyes and mucous membranes with copious amounts of water
For eye involvement, irrigate with **Normal Saline 1L** during transport; allow patient to remove contact lenses if possible.
8. Initiate cardiac monitoring (*MCG 1308*)
Perform 12-lead ECG prn
For patients with dysrhythmias, treat in conjunction with *TP 1212, Cardiac Dysrhythmia-Bradycardia* or *TP 1213, Cardiac Dysrhythmia- Tachycardia*
9. Establish vascular access prn (*MCG 1375*)
10. Assess for signs of trauma
If traumatic injury suspected, treat in conjunction with *TP 1244, Traumatic Injury*
11. For poor perfusion (*MCG 1355*):
Normal Saline 1L IV rapid infusion
Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

For persistent poor perfusion, treat in conjunction with *TP 1207, Shock/Hypotension*
12. Consider contacting the Poison Control Center in conjunction with the Base Hospital for assistance with management of toxins (*Ref. 805*)

NERVE AGENT EXPOSURE

13. If multiple symptomatic patients with > 50 victims involved, request EMS Chempack from the MAC (*Ref. 1108*)

14. For SEVERE EXPOSURE: ❶
Begin treatment immediately (concurrent with decontamination) and transport after decontamination procedures are completed
DuoDote (Atropine 2.1mg and Pralidoxime Chloride 600mg) IM x3, one after another

For seizure, treat in conjunction with *TP 1231, Seizure*
15. For MODERATE EXPOSURE: ❶
Ensure decontamination procedures are completed before treatment or transport to facility
DuoDote IM x2, one after another
16. For MILD EXPOSURE: ❶
Ensure decontamination procedures are completed before treatment or transport to facility
DuoDote IM x1
17. If symptoms in MILD or MODERATE exposures progress after initial evaluation, administer additional **DuoDote IM for a total of 3 doses**

ORGANOPHOSPHATE EXPOSURE

18. For heart rate < 60bpm, hypotension, respiratory depression and/or extreme salivation
Atropine 2mg (20mL) IV/IO ❷
May be repeated every 5 min until patient is asymptomatic

For seizure, treat in conjunction with *TP 1231, Seizure*

RADIOLOGIC EXPOSURE

19. If radiation contamination is suspected, confirm by using appropriate detection devices available through Department of Public Health (DPH), Radiation Management at (213) 989-7140
20. If radiation contamination present, identify the cause of the contamination ❸
Internal Radiation is exposure through open wound, ingestion or inhalation of radioactive materials
External Radiation is exposure through a Radiological Dispersal Device (RDD), Radiological Material Release (RMR) or Radiological Exposure Device (RED)
21. For External Radiation:
If a RDD is used and in the absence of any other information, evacuate 1,650 feet in all directions from the detonation site and then contact the MAC ❸
Notify DPH Radiation Management at (213) 989-7140 if departmental HAZMAT team is not available and prolonged exposures are expected ❹
22. For patients with a life threatening condition:
Treat using appropriate treatment protocol based on complaints in conjunction with decontamination
Remove the outer clothing and utilize containment mitigation techniques before transport

23. For patients without a life threatening condition:
Decontaminate using departmental protocols
Treat using appropriate treatment protocol based on complaints

24. Asymptomatic and minimal exposure suspected:
Decontaminate and release patient if appropriate ⑤

CYANIDE EXPOSURE

25. For patients with cardiovascular, neurologic, and/or respiratory compromise due to suspected or known cyanide exposure:
Hydroxocobalamin 5 grams in 200mL of Normal Saline IV/IO (25mg/ml) infused over 15 minutes
May repeat x1 in 15 min

SPECIAL CONSIDERATIONS

- ① Nerve agent exposure symptom severity:
SEVERE: severe respiratory distress, respiratory arrest, cyanosis, extreme SLUDGE (salivation, lacrimation, urination, defecation, gastrointestinal distress and emesis) seizures, unconsciousness
MODERATE: miosis, rhinorrhea, shortness of breath, vomiting, diarrhea
MILD: miosis, rhinorrhea and increased salivation
- ② High cumulative doses may be required, maximum single dose 2mg.
- ③ Radiation Exposure Safety:
Exposure to victims with internal radiation poses low-to-no risk to EMS personnel
Exposure to victims with external radiation exposure poses low-to-moderate risk to EMS personnel
Remember the following principles:
Time: limit time with the victim to a minimum
Distance: the further away from the source, the smaller the dose received.
Shielding: "Turnouts" will protect from alpha and beta emitters, wear respiratory protection if particulate matter (i.e., dust or powder) present
- ④ The HazMat team, MAC, or DPH Radiation Management will be able to redefine boundaries, establish radiation dose guidelines, assist with monitoring and decontamination procedures, and provide support to on-scene responders. These resources may also refer to *Emergency Response Guidebook* for other recommended scene precautions.
- ⑤ If number of patients exceeds available resources, asymptomatic patients with minimal exposure may be released for home decontamination.



Contact Medical Alert Center (MAC) for all MCIs prior to transport otherwise notify the receiving hospital ①

1. Secure area, establish incident site, and don protective equipment/gear appropriate for hazardous material exposure according to the provider agency protocol
2. If MCI, begin triage (*Ref. 519.2 and Ref. 519.5*)
Provide MAC with the following incident information: properties of contaminant, type of decontamination performed, signs/symptoms, and smells
3. Remove patient from source if safe to do so, and move to decontamination area prn
4. Assess airway and initiate basic and/or advanced airway maneuvers prn (*MCG 1302*)
5. Administer **Oxygen** prn (*MCG 1302*)
6. Remove patient's clothing
7. Flush skin, eyes and mucous membranes with copious amounts of water
For eye involvement, irrigate with **Normal Saline 1L** during transport; allow patient to remove contact lenses if possible
8. Initiate cardiac monitoring (*MCG 1308*)
Perform 12-lead ECG prn
For patients with dysrhythmias, treat in conjunction with *TP 1212-P, Cardiac Dysrhythmia - Bradycardia* or *TP 1213-P, Cardiac Dysrhythmia - Tachycardia*
9. Establish vascular access prn (*MCG 1375*)
10. Assess for signs of trauma
If traumatic injury suspected, treat in conjunction with *TP 1244-P, Traumatic Injury*
11. For poor perfusion (*MCG 1355*):
Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*
For persistent poor perfusion, treat in conjunction with *TP 1207-P, Shock/Hypotension*
12. Consider contacting the Poison Control Center in conjunction with the Base Hospital for assistance with management of toxins (*Ref. 805*)

NERVE AGENT EXPOSURE

13. If multiple symptomatic patients with > 50 victims involved, request EMS CHEMPACK from the MAC (*Ref. 1108*)
14. Pediatric patients **longer** than the length-based resuscitation tape (Broselow™) should be treated according to adult doses which are listed below and found in *TP 1240, HAZMAT ②*
Mild Exposure: 1 DuoDote IM



Moderate Exposure: 2 DuoDotes IM, one after the other
Severe Exposure: 3 DuoDotes IM, one after the other

15. Pediatric patients between **3 – 36 kilograms** body weight based on measurement using the length-based resuscitation tape (Broselow™) should be treated as follows: ②

Mild Exposure: **Atropine (0.1mg/mL) 0.02mg/kg IV/IM**, dose as per *MCG 1309*

Moderate Exposure: 1 DuoDote IM

Severe Exposure: 1 or 2 DuoDote(s) IM, one after the other when applicable, based on the table below:

Avg Wt (KG)	Color	Initial Emergency Dose
4	Grey	1 DuoDote
6.5	Pink	
8.5	Red	
10.5	Purple	
13	Yellow	
16.5	White	
20.5	Blue	
26	Orange	2 DuoDotes
33	Green	

*Duodote (2.1mg Atropine/600 mg 2PAM Chloride)

16. For seizure, treat in conjunction with *TP 1231-P, Seizure*

17. For EMS CHEMPACK Deployment:
 EMS CHEMPACK may be utilized for repeat dosing as necessary
 Repeat dose prn 5 minutes after initial emergency DuoDote

Avg Wt (KG)	Color	Repeat Atropine Dose Multi-dose vial (0.4mg/mL) 0.1mg/kg IV or IM	2PAM Chloride* Multi-dose vial (50mg/mL) 50 mg/kg IM or IV	Diazepam** Multi-dose vial (5mg/mL) 0.1mg/kg IV or IM prn seizure
4	Grey	0.4mg, 1mL	200mg, 4mL	0.4 mg, 0.08mL
6.5	Pink	0.7mg, 1.75mL	325mg, 6.5mL	0.6 mg, 0.12mL
8.5	Red	0.9mg, 2.25mL	425mg, 8.5mL	0.8 mg, 0.16mL
10.5	Purple	1mg, 2.5mL	525mg, 10.5mL	1 mg, 0.2mL
13	Yellow	1.3mg, 3.25mL	650mg, 13mL	1.3 mg, 0.26mL
16.5	White	1.6mg, 4mL	825mg, 16.5mL	1.6 mg, 0.32mL
20.5	Blue	2mg, 5mL	1000mg, 20mL	2 mg, 0.4mL
26	Orange	2.6mg, 6.5mL	1000mg, 20mL	2.6 mg, 0.52mL
33	Green	3.3mg, 8.25mL	1000mg, 20mL	3.3 mg, 0.66mL

Atropine multi-dose vials can provide closer to ideal dosages, if available

*Repeat dose 60 minutes after Initial Emergency DuoDote

** For seizure, if utilizing the CHEMPACK, treat seizure with Diazepam as per above table.

IV preferred route for Diazepam but can administer IM if not IV available

May repeat diazepam dose x1 in 5 min, maximum total dose 5mg

If diazepam not available treat in conjunction with *TP 1231-P, Seizure*



If the child is too tall for the pediatric resuscitation tape and adult size, treat per adult protocol
[TP 1240, HAZMAT](#)

ORGANOPHOSPHATE EXPOSURE

18. For heart rate < 60bpm, hypotension, respiratory depression and/or extreme salivation
Atropine (0.1mg/mL) 0.05mg/kg IV/IO
May be repeated every 5 min, maximum total dose 5mg

For seizure, treat in conjunction with [TP 1231-P, Seizure](#)

RADIOLOGIC EXPOSURE

19. If radiation contamination is suspected, confirm by using appropriate detection devices available through Department of Public Health (DPH), Radiation Management at (213) 989-7140
20. If radiation contamination present, identify the cause of the contamination ③
Internal Radiation is exposure through open wound, ingestion or inhalation of radioactive materials
External Radiation is exposure through a Radiological Dispersal Device (RDD), Radiological Material Release (RMR) or Radiological Exposure Device (RED)
21. For External Radiation:
If a RDD is used and in the absence of any other information, evacuate 1,650 feet in all directions from the detonation site and then contact the MAC ③
Notify DPH Radiation Management at (213) 989-7140 if departmental HAZMAT team is not available and prolonged exposures are expected ④
22. For patients with a life-threatening condition:
Treat using appropriate treatment protocol based on complaints in conjunction with decontamination
Remove the outer clothing and utilize containment mitigation techniques before transport
23. For patients without a life-threatening condition:
Decontaminate using departmental protocols
Treat using appropriate treatment protocol based on signs and symptoms
24. Asymptomatic and minimal exposure suspected:
Decontaminate and release patient if appropriate ⑤

CYANIDE EXPOSURE

25. For patients with cardiovascular, neurologic, and/or respiratory compromise due to suspected or known cyanide exposure:



Treatment Protocol: HAZMAT

Ref. No. 1240-P

Hydroxocobalamin 70mg/ml IV/IO, dose per MCG 1309

Reconstitute 5 grams in 200mL of Normal Saline (25mg/ml) and infuse over 15 minutes

May repeat x1 in 15 min





SPECIAL CONSIDERATIONS

- ① If MCI, MAC should be contacted for 5 or more patients and coordinate all destination decisions otherwise the Base Hospital should be notified as specified in this protocol, and if no Base Hospital required then the receiving hospital will be notified.
- ② Nerve agent exposure symptom severity:
SEVERE: severe respiratory distress, respiratory arrest, cyanosis, extreme SLUDGE (salivation, lacrimation, urination, defecation, gastrointestinal distress and emesis) seizures, unconsciousness
MODERATE: miosis, rhinorrhea, shortness of breath, vomiting, diarrhea
MILD: miosis, rhinorrhea and increased salivation
- ③ Radiation Exposure Safety:
Exposure to victims with internal radiation poses low-to-no risk to EMS personnel
Exposure to victims with external radiation exposure poses low-to-moderate risk to EMS personnel
Remember the following principles:
Time: limit time with the victim to a minimum
Distance: the further away from the source, the smaller the dose received.
Shielding: "Turnouts" will protect from alpha and beta emitters, wear respiratory protection if particulate matter (i.e., dust or powder) present
- ④ The HAZMAT team, MAC, or Department of Public Health Radiation Management will be able to redefine boundaries, establish radiation dose guidelines, assist with monitoring and decontamination procedures, and provide support to on-scene responders. These resources may also refer to *Emergency Response Guidebook* for other recommended scene precautions.
- ⑤ If number of patients exceeds available resources, asymptomatic patients with minimal exposure may be released for home decontamination.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MEDICAL CONTROL GUIDELINES**

REFERENCE NO. 1300

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Care of the Patient with Agitation	1307
Flowchart for Initial Approach to Scene Safety	1307.1
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Flowchart for Initial Approach to Scene Safety	1307.3
EMS and Law Enforcement Co-Response	1307.4
Cardiac Monitoring/12-Lead ECG	1308
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Glucagon	1317.21
Hydroxocobalamin	1317.21
Ketorolac	1317.22
Ketorolac	1317.22
Lidocaine	1317.23
Midazolam	1317.25
Morphine Sulfate	1317.27
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[DRAFT] Medical Control Guideline: Evaluation and Care of Patients At Risk of Suicide

DEFINITIONS:

Suicide Risk Screening: A standardized method to identify individuals who may be at risk for suicide, and to estimate a patient's current level of risk for suicide by asking specific questions about a patient's thoughts and behaviors.

The Columbia Suicide Severity Rating Scale (C-SSRS, <https://cssrs.columbia.edu/>) is a commonly used, evidence-based method of suicide risk screening that can be administered by a variety of personnel, such as all healthcare personnel, law enforcement personnel, educators, clergy, and the lay public. See MCG XXX.1 for C-SSRS. (Note: The C-SSRS is validated in patients from ages 6 and above, though many younger children can also understand the questions.)

Suicide Risk Assessment: A thorough and systematic evaluation that is typically performed after suicide risk screening. A trained mental health clinician (e.g. a psychiatrist, social worker, or psychologist in an ED or PUC setting) performs a detailed clinical assessment to confirm suspected suicide risk, to estimate the immediate danger, and to delineate treatment. Assessment takes into account chronic and acute risk factors, protective factors, and medical and mental health history.

Suicidal Ideation (SI): Thoughts of death or ending one's life. Different types of SI include the following (in increasing level of severity):

Passive SI: A wish to be dead or to go to sleep and not wake-up	(C-SSRS Q1)
Active SI: Actual thoughts of wanting to kill oneself	(C-SSRS Q2)
Suicide Method: Contemplation of one or more ways or means of ending their life, <i>without</i> formulating a specific plan	(C-SSRS Q3)
Suicidal Intent: Intention to act on suicidal thoughts or behaviors, with the specific goal to kill oneself or to die	(C-SSRS Q4)
Suicide Plan: Specific thoughts of converting a method to a plan, such as deciding on the timing, location, and/or preparations to end their life (e.g., gathering pills, acquiring a weapon, writing a suicide note, researching the location for a traumatic/deadly injury)	(C-SSRS Q5)

Suicide Attempt: A self-injurious behavior where a person specifically intends to die **(C-SSRS Q6)**

Suicide: Death caused by self-injurious behavior with any intent to die as a result of that behavior. (Note: The following terms are discouraged from use: "completed suicide", "successful suicide", and "failed suicide". Preferred terms are "suicide" and "suicide attempt".)

Self-injurious behaviors: Behaviors in which a person intentionally harms themselves, with or without intent to die (a patient's intent to die must be specifically asked, or implied). For example, patients may "self-harm" (e.g., cutting, burning, or punching oneself), without intent to die, as a way of attempting to cope with emotional distress or psychological pain.

Suicidal behaviors: Self-injurious behavior *with the intent to die*.

Safety Planning: Interventions made by healthcare personnel, first responders, or others, to reduce the patient’s risk of suicide or self-harm.

5150 / 5585 (AKA “Hold”, “Psychiatric Hold”, “Mental Health Hold”, or “LPS Hold”):

Refers to California Welfare and Institutions Code (WIC) section 5150 et seq. which describes the legal standard for involuntary detention and evaluation of a person who, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled. “5150” refers to the code for adult patients, “5585” refers to the code for minors (under age 18).

Danger to Self: The term used in CA WIC 5150 et seq, to define probable cause for detaining a patient involuntarily for the purpose of evaluation, who as a result of a mental illness poses a risk to themselves (e.g., has suicidal ideation or behavior).

LPS-Evaluator: An individual that is authorized under CA WIC 5150 et seq. to evaluate and place a patient on a 5150/5585 hold application, such as all law enforcement (LE) personnel and clinicians who are LPS-authorized by the County Department of Mental Health. Examples include: Psychiatric Emergency Team (PET), Psychiatric Mobile Response Team (PMRT), Mental Evaluation Team (MET), Systemwide Mental Assessment Response Teams (SMART), or others). LPS refers to “Lanterman-Petris-Short”, the names of the original state legislators who authored the CA WIC 5150 et seq. code.

LPS facility: Treatment facilities that are specifically designated by the county for mental health evaluation and treatment, approved by the State Department of Health Care Services, and licensed as a health facility as defined in the CA Health and Safety Code (subdivision (a) or (b) of Section 1250 or 1250.2).

Against Medical Advice (AMA): A patient, or a legal representative of a patient, who has decision-making capacity and who refuses treatment and/or transport for an emergency medical condition as advised by EMS providers, physician on scene, and/or Base personnel.

Decision-Making Capacity: The ability to understand the nature and consequences of proposed health care. This includes understanding the significant risks and benefits, and having the ability to make and communicate a decision regarding the proposed health care in the patient’s primary language, if feasible. A person has decision-making capacity if they are able to:

- Communicate the need for treatment, the implications of receiving and of not receiving treatment, and alternative forms of treatment that are available, and
- Relate the above information to their personal values, and then make and convey a decision.

A person may lack decision-making capacity as follows:

- Temporarily lost (e.g., due to unconsciousness, influence of mind-altering substances, mental illness, or cognitive impairment)
- Permanently lost (e.g., due to irreversible coma, persistent vegetative state, untreatable brain injury, or dementia)
- Never existed (i.e., due to profound neurodevelopmental or medical disorder),
- Legally determined to lack capacity (i.e. persons who are deemed incompetent by a Court, or a person under conservatorship)

9-8-8: The three digit emergency number for the 24/7 National Suicide and Crisis Lifeline that provides free and confidential emotional support to people in suicidal crisis or emotional distress.

PRINCIPLES:

1. Psychiatric emergencies (including those related to mental health and substance abuse) are emergent clinical conditions, and as such are best treated by EMS personnel who are trained, equipped, and experienced to evaluate and manage such patients.
2. Several suicide risk screening tools are evidence-based and validated. They consist of simple, plain-language questions that anyone can ask, and are free and available online (such as the C-SSRS and ASQ). Suicide risk screening has been promoted by numerous public health agencies (CDC, AHRQ, WHO, FDA, SAMHSA, and CDPH), and is similar to public health campaigns related to knowing the signs of stroke or bystander CPR.
3. Suicide risk screening can be performed by EMS personnel to assist with the evaluation of patients who express suicidal ideation or behaviors.
4. CA WIC 5150 et seq. defines the situations when a patient may be involuntarily detained and transported on a psychiatric hold, and who is authorized to issue a psychiatric hold.

GUIDELINES:

1. Evaluate the patient for medical conditions immediately if the patient has made a suicide attempt or is suspected of making a suicide attempt. Manage medical conditions with the appropriate treatment protocol based on provider impression.
2. Evaluate primary psychiatric crises by obtaining relevant clinical history and managing per treatment protocol (*TP 1209 or 1209-P, Behavioral/Psychiatric Crisis*).
3. It is critical to establish rapport with the patient to facilitate trust and open communication and to optimize the evaluation and screening of suicide risk.
4. The evaluation of suicide risk should generally include an inquiry of the patient's suicidal ideation and behaviors, including whether the patient has passive SI, active SI, contemplation of suicide method, intent to die by suicide, a plan to commit suicide, and/or suicide attempts.
 - A. To assist with evaluating the level of suicide risk, it is recommended to utilize the Columbia Suicide Severity Risk Scale (C-SSRS) to administer standardized screening questions (MCG XXX.1). C-SSRS questions should be asked verbatim, all instructions should be followed, and attention paid to the specified time frames.
 - B. For recommendations regarding disposition, refer to MCG XXX.1
5. Evaluate the reliability of information, especially in situations where a patient may be suspected of minimizing or evading questions about SI or suicidal behaviors.
 - A. Obtain information from key third parties when feasible.
 - B. Document if the patient lacks capacity or is unwilling to participate in the evaluation.

6. When a patient has been evaluated by an authorized LPS-Evaluator (including LE) regarding placement of a 5150/5585 hold, that evaluation shall generally take precedence in determining whether a patient can be transported involuntarily.
 - A. Exceptions include when the EMS provider determines that the patient has a medical need that requires transport to a medical facility. (e.g., need for evaluation for trauma or other emergency physical conditions)
 - B. For patients that do not meet criteria for a 5150/5585 hold, base contact is required for AMA.
7. In situations where there may be disagreement with LE or an LPS-evaluator regarding the placement or non-placement of a 5150/5585 hold, and/or transport that cannot be resolved, the following steps should be taken.
 - A. EMS provider shall contact higher authority (e.g. EMS Captain or Battalion Chief) to seek resolution, which may be facilitated by a call with the LE or LPS higher authorities.
 - B. LE provider should contact higher authority (e.g. Field supervisor or Watch commander).
 - C. LPS evaluators (such as PET, SMART, MET) should contact higher authority
 - D. In cases of continued disagreement, LE or LPS evaluator determination takes precedence as they are the legal authority for placement or non-placement of a 5150/5585 hold; document the course of escalation and LPS/LE evaluator information.
8. Safety planning: EMS providers can perform safety planning to help reduce the patient's risk of suicide or self-harm with the following interventions:
 - A. **Establish mental health services:** Provide the national suicide lifeline phone number (9-8-8), and recommend the patient call their mental health provider, or take steps to establish mental health care (e.g., LA County Department of Mental Health 800-854-7771, or contact their insurance provider)
 - B. **Help the patient identify support contacts:** Identify a family member, friend or other trusted individual who they can reach out to for help and recommend that they be accompanied or supported in the short term.
 - C. **Reduce access to suicide means:** Provide direction to the patient or key third parties (e.g., family, friends) to remove or secure any identified or potential means of suicide, especially firearms, knives, pills, or other toxins.

Firearms can be secured through use of gun locks, storage lockers, or transferred to family or friend for safekeeping. LE personnel can also be contacted to advise about securing firearms.
 - D. **Reduce the risk of alcohol or drugs:** Recommend that the patient avoid use of alcohol or any other drugs, and/or take steps to limit their availability.

DRAFT - MCG XXX.1 Recommended Standardized Screening for Suicide Risk: Columbia Suicide Severity Risk Scale (C-SSRS)

**Instructions: Ask questions in quotations, mark “yes” or “no”.
Follow the instructions in the grey prompts.**

	YES	NO	EMS Decision Support
1. “In the past month, have you wished you were dead or wished you could go to sleep and not wake up?” <i>(Passive SI)</i>	low risk		Low Risk: Recommend voluntary evaluation at MAR/PUCC. <ul style="list-style-type: none"> If patient refuses, and <u>has</u> decision making capacity, contact Base to discuss AMA and engage in safety planning. If patient refuses, and <u>lacks</u> decision making capacity, contact LE or LPS evaluator for eval of a 5150/5585 hold. If pt does not meet hold criteria, contact Base to discuss AMA. Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.
2. “In the past month, have you actually had any thoughts about killing yourself?” <i>(Active SI)</i>	low risk		
If YES to 2, ask questions 3, 4, 5 and 6 If NO to 2, ask question 6			
3. “Have you thought about how you might do this?” <i>(Suicide method)</i>	moderate risk		Moderate or High Risk: Immediate mental health evaluation is indicated, transport to MAR/PUCC. <ul style="list-style-type: none"> Maintain close observation of the patient and awareness of the potential for elopement or self-injurious behavior For patients who refuse transport, contact law enforcement (or LPS evaluator) for eval of a 5150 / 5585 hold. If pt does not meet hold criteria, contact Base to discuss AMA. Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.
4. “Have you had any intention of acting on these thoughts of killing yourself” (as opposed to you have the thoughts but you definitely would not act on them)? <i>(Suicide intent)</i>	high risk		
5. “Have you started to work out, or worked out, the details of how to kill yourself? Do you intend to carry out this plan?” <i>(Suicide plan)</i>	high risk		
Always Ask Question 6			
6a. “Have you ever done anything, started to do anything, or prepared to do anything to end your life?” Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, went to the roof but didn't jump, tried to hang yourself, etc. <i>(Suicide attempt)</i>	moderate risk		
6b. “Was this in the past 3 months?” <i>(Suicide attempt, recent)</i>	high risk		

MAR = Most Accessible Receiving facility, PUCG = Psychiatric Urgent Care Center (Ref No. 526)

Recommended guidance for disposition:

Determination of patient disposition shall consider all information obtained during the field evaluation and should not rely solely on the results of the C-SSRS screening, including: the patient's medical and behavioral or psychiatric condition, information from key third parties, as well as any mental health evaluation performed by an LPS-Evaluator, if applicable.

In general, patients will be transported to the MAR or PUCG when EMS is called to respond either on a voluntary basis or on a 5150 / 5585 hold. For patients with decision-making capacity refusing transport against medical advice, standardized suicide risk screening is a useful tool to facilitate communication between EMS, LE and the Base Hospital.

1. Patients who are low-risk should receive a voluntary evaluation at the MAR or PUCG (Reference No. 526, Behavioral / Psychiatric Crisis Patient Destination).
 - A. For patients with decision-making capacity (or guardians in the case of minors) who refuse transport, and who have not been placed on a 5150/5585 hold, contact Base to discuss AMA. Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.
 - B. Patients who lack decision-making capacity, should be transported to MAR/PUCG for further evaluation. For patients who refuse transport, contact LE or an LPS-Evaluator for evaluation of a 5150/5585 hold. If patient does not meet criteria for hold, contact Base to discuss AMA. Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.
2. Patients who are moderate-risk or high-risk require immediate mental health evaluation at the MAR or PUCG (Ref No. 526).
 - A. Maintain close observation of the patient and awareness of the potential for elopement or self-injurious behavior
 - B. For patients who refuse transport, contact LE or an LPS-Evaluator for evaluation of 5150/5585 hold. Results from the field evaluation and C-SSRS should be shared with LE or LPS-Evaluator. If patient does not meet criteria for hold, contact Base to discuss AMA. Report your C-SSRS screening results when communicating with the Base to aid with AMA decision-making.

Agency	Entire Study Period			October 2024		
	Pediatric Seizure Transports	Completed PSR's	PSR Completion rate (Total)	Pediatric Seizure Transports	Completed PSR's	PSR Completion rate (OCT 2024)
AF-Arcadia Fire	28	26	93%	No eligible runs this period	-	-
AH-Alhambra Fire	91	67	74%	1	1	100%
BF-Burbank Fire	94	52	55%	2	2	100%
BH-Beverly Hills	17	11	65%	1	1	100%
CC Culver City Fire	36	26	72%	1	1	100%
CF-LA County Fire	4403	343	8%	159	61	38%
CI-LA City Fire	3439	1316	38%	100	50	50%
CM-Compton Fire	139	96	69%	4	2	50%
CS- LA Sherrif	4	2	50%	No eligible runs this period	-	-
DF-Downey Fire	128	31	24%	7	5	71%
ES-EI Segundo Fire	27	21	78%	No eligible runs this period	-	-
GL-Glendale Fire	150	82	55%	8	6	75%
LB-Long Beach Fire	527	263	50%	20	14	70%
LH -La Habra Heights Fire	9	5	56%	No eligible runs this period	-	-
LV-La Verne Fire	36	6	17%	No eligible runs this period	-	-
MB-Manhattan Beach	38	12	32%	3	1	33%
MF-Monrovia Fire	40	25	62%	No eligible runs this period	-	-
MO-Montebello Fire	67	5	7.00%	No eligible runs this period	-	-
MP-Monterey Park	44	22	50%	No eligible runs this period	-	-
PF-Pasadena Fire	105	58	55%	5	4	80%
RB-Redondo Beach	51	28	55%	No Eligible Runs this period	-	-
SA-San Marino Fire	8	6	75%	No Eligible Runs this period	-	-
SG-San Gabriel Fire	45	27	60%	No Eligible Runs this period	-	-
SI-Sierra Madre Fire	6	3	50%	1	1	100%
SM-Santa Monica Fire	42	26	62%	No Eligible Runs this period	-	-
SP-South Pasadena	12	7	58%	No Eligible Runs this period	-	-
SS-Santa Fe Springs Fire	22	9	41%	No Eligible Runs this period	-	-
TF-Torrance Fire	141	50	35%	7	4	57%
WC-West Covina Fire	88	22	25%	No Eligible Runs this period	-	-



LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
EMS AGENCY MEETING SCHEDULE
 2025



NOTE: Meeting dates and times are subject to change

Revised August 27, 2024

COMMITTEE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
EMS Commission <i>(3rd Wednesday – ODD months) 1:00 pm</i>	15		12		21		16		10		19	
Base Hospital Advisory Committee <i>(2nd Wednesday – EVEN months) 1:00 pm</i>		5		9		11		13		8		10
Provider Agency Advisory Committee <i>(3rd Wednesday – EVEN months) 1:00 pm</i>		12		16		18		20		15		17
Pediatric Advisory Committee <i>(1st Tuesday – Quarterly) 10:00 am</i>			4			3			2			2
Medical Council <i>(1st Tuesday – Quarterly) 1:00 pm</i>			4			3			2			2
Trauma Hospital Advisory Committee <i>(4th Wednesday – ODD months) 1:00 pm</i>	22		26		28		23		24			3
EMS Orientation <i>(Last Tuesday – Quarterly) 8:00 am</i>	28			29			29			28		
Innovation, Technology and Advancement Committee <i>(1st Monday – Quarterly) 10:00 am</i>		3			5			4			3	
EMS and LE Co-Response (ELCoR) <i>(2nd Monday – Quarterly) 10:00 – 11:30 am</i>	13			14			14			6		
EMS Dispatch <i>(Last Monday – Quarterly) 10:00 am</i>	27			28			28			27		
ACN – Building Emergency Coordinators Meeting <i>(4th Wednesday – Quarterly) 9:00 am</i>	22			23			23			22		
Disaster Coalition Advisory Meeting <i>(1st Thursday – every 4th month) 9:30 am</i>		6				5				2		



LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
**EMS AGENCY QUALITY IMPROVEMENT AND
 DATA COLLABORATIVE MEETING SCHEDULE**
 2025



**EMERGENCY MEDICAL
 SERVICES AGENCY**
 LOS ANGELES COUNTY

Attendance Is Invitation Only

NOTE: Meeting dates and times are subject to change

Revised August 27, 2024

COMMITTEE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
EMS QI Committee Base Hospital and Public Provider <i>(2nd Thursday – Quarterly) 1:00 pm</i>			13			12			11			11
EMS Private Provider QI Committee <i>(1st Thursday – every 4th month) 1:00 pm</i>				3				7				4
Pediatric Data Collaborative <i>(1st Monday – Quarterly) 9:00 – 10:00 am</i>		3			5			4			3	
SRC Data Collaborative <i>(1st Wednesday – Quarterly) 12:00 – 1:00 pm</i>			5			4			3			3
Stroke Data Collaborative <i>(2nd Monday – Jan/July, Morning of Stroke Advisory Meeting Apr/Oct) 11:30 – 12:30 pm</i>	13			TBT			14			TBT		
SRC Advisory Committee <i>(May and Oct) 1:00 – 3:00 pm</i>					6					TBT		
Stroke Advisory Committee <i>(Apr and Oct) 1:00 – 3:00 pm</i>				TBT						TBT		

The proceedings of EMS Quality Improvement (QI) Committee meetings shall be free from disclosure and discovery (California Evidence Code, Section 1157.7) and held as confidential peer review meetings with all communications deemed part of the peer review process. Remaining in these meetings mean that participants agree to protect these confidential materials from disclosure, and that participants will not divulge any specific data or information obtained from these committees unless authorized by appropriate agency/hospital. Confidentiality requires not allowing unacknowledged individuals to observe/attend these meetings.